

The Experiences of Men whose Partners have been Admitted to an Intensive Care Unit (ICU) Immediately after Childbirth.

A thesis submitted in fulfilment of the requirements for the degree of
Master of Nursing in Research

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November 2007

Table of Contents

TABLE OF CONTENTS	i
LIST OF TABLES	vii
ABSTRACT	viii
DECLARATION	ix
ACKNOWLEDGEMENTS	x
AIMS AND OBJECTIVES OF THE RESEARCH	xi
ABBREVIATIONS	xii
GLOSSARY OF TERMS	xiii
1.0 INTRODUCTION	
1.1 INTRODUCTION	1
1.2 Background to the study	1
1.2.1 Intensive care environment	2
1.2.2 Maternal deaths	3
1.2.3 Breast feeding	5
1.2.4 Stress of impending fatherhood	6
1.2.5 Obstetric patients in ICU	7
1.2.6 ICU obstetric patient data	8
1.3 Scope of the study	9
1.4 Research aims	10
1.5 Research questions	11
1.6 Synopsis of chapters	11
2.0 LITERATURE REVIEW	
2.1 INTRODUCTION	13
2.2 Complications after childbirth	13
2.3 The waiting room	14
2.4 Visitation in ICU	15
2.5 Informational needs of the critically ill patient's family	17
2.6 Caring for the obstetric patient in ICU	18

2.7	Physiological changes during pregnancy	19
2.8	Births and maternal mortality	20
2.9	Non-parent to parent	22
2.10	Postpartum woman in ICU	23
2.11	Tumultuous time for the men	25
2.12	Family roles and responsibilities	26
2.13	Psychological trauma	26
2.14	Secondary trauma	27
2.15	Conclusion	28

3.0 METHODOLOGY AND METHOD

3.1	INTRODUCTION	29
3.2	Methodology	29
3.2.1	Philosophical underpinnings of Naturalistic Inquiry	31
3.2.2	Enable participants to tell 'their stories'	33
3.2.3	Steps of data collection and data analysis	35
3.3	Method	36
3.3.1	Sample selection	37
3.3.1.1	Sample recruitment and access	40
3.3.1.2	Sample description	42
3.3.2	Data Collection	43
3.3.3	Data analysis	49
3.3.4	Presentation and dissemination of research findings	50
3.4	Research rigour and validity	51
3.4.1	Credibility	51
3.4.2	Auditability	53
3.4.3	Fittingness	54
3.5	Limitations of the study	55
3.6	Ethics approval process	58
3.6.1	Informed consent	58
3.6.2	Confidentiality	58
3.6.3	Anonymity	58
3.6.4	Level of risk	59
3.7	Conclusion	60

4.0 DATA PRESENTATION AND ANALYSIS

4.1	INTRODUCTION	61
4.1.1	Findings	61
4.2	Men's experiences and perceptions of their partners' admission to ICU	62
4.2.1	Men's expectations of their partners' birthing	62
4.2.2	Experience and witnessing their partners crisis	64
4.2.2.1	Men not present during partners' obstetric crisis	65
4.2.2.2	Not enough information	66
4.2.2.3	Couldn't do anything properly	66
4.2.3	Men's partners admitted to theatre	67
4.2.3.1	Not much choice	67
4.2.3.2	Men not knowing partners' outcomes	68
4.2.3.3	Communication and imparting of information	69
4.2.3.4	Left alone to wait	69
4.2.3.5	Feeling lucky	71
4.2.3.6	Wanting reassurance and guidance	72
4.2.3.7	Partner missing out	72
4.3	The relationships and interactions with healthcare professionals	73
4.3.1	In relation to care delivery to the partner and newborn infant	73
4.3.1.1	Let down by the healthcare system	74
4.3.2	The relationship and interactions with healthcare professionals during the crisis prior to admission to ICU	75
4.3.2.1	Partner about to die	75
4.3.2.2	Body language	76
4.3.2.3	Accepting of physiological assaults on partner during time of crisis	78

4.3.2.4	Surreal situation	79
4.3.2.5	Digesting information	80
4.3.2.6	Visiting in ICU	81
4.3.2.7	Impressions of ICU	82
4.3.2.8	Feeling sorry for others	82
4.3.2.9	Sit down and take stock	83
4.3.2.10	At the mercy of healthcare professionals	84
4.3.3	The relationship and interactions with healthcare professionals during the crisis during the admission to ICU	85
4.3.3.1	Flustered and upset	85
4.3.3.2	Detached, very clinical and apathetic	85
4.3.3.3	Healthcare professionals in a hurry	86
4.3.3.4	Importance of a family meeting	86
4.4	Impact on the men and their family during their partners' admission to ICU	87
4.4.1	Too afraid to ask questions	87
4.4.2	Juggling visits between two hospitals	88
4.4.3	Trying to deal with it	88
4.4.3.1	Coping mechanisms	88
4.4.3.2	Unexpected complications after childbirth	89
4.4.4	Impact on family members (including children)	89
4.4.4.1	In relation to newborn infant	90
4.4.4.2	Not bringing newborn infant into ICU	90
4.4.4.3	In relation to other children	90
4.4.4.4	Decisions regarding other children visiting ICU	90
4.4.5	Impact on men's well-being	91
4.4.5.1	In relation to other family members	92
4.4.5.2	Coordination extended family visits to ICU	92
4.4.5.3	Limiting time spent with partner in ICU	92
4.4.5.4	Through the dangerous period	93
4.5	Men's fears and anxieties during the crises and their legacy	93
4.5.1	Feeling petrified	94
4.5.2	Helpless to assist partner	95

4.5.3	Feeling invisible	95
4.5.4	Thoughts that partner might die	96
4.5.4.1	Touch and go	96
4.5.5	Men physically unwell	97
4.5.6	Feeling alone and isolated	98
4.5.7	Feeling torn	98
4.5.8	Legacy of fears and anxieties	99
4.5.8.1	Scary memories	99
4.5.8.2	Never forget	100
4.5.8.3	Ignore it	101
4.5.8.4	Depression exacerbated	102
4.6	The impact on men and their future life plans	102
4.6.1	Decision not to have more children	102
4.6.1.1	Consequences of another baby	103
4.6.1.2	Obstetrician positive	104
4.6.2	Impact on work	104
4.6.2.1	Couldn't work	104
4.6.2.2	Men's role in the household	106
4.6.2.3	Inability to work	106
4.6.3	Annoyed with friends	107
4.6.4	Family arguments	107
4.6.5	Questioning healthcare professionals	109
4.7	Conclusion	109

5.0 DISCUSSION OF FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.1	INTRODUCTION	110
5.2	Aims and objectives of the study	110
5.3	Discussion of findings	111
5.3.1	Antenatal classes	112
5.3.2	Healthcare professional's interaction with the men	112
5.3.3	Financial burden	115
5.3.4	Worried about the future	116

5.4	Recommendations	117
5.4.1	Antenatal classes	117
5.4.2	Empathetic healthcare professional	117
5.4.3	Maternal Child Healthcare Centres	118
5.4.4	Policy making to guide healthcare professionals	118
5.4.5	Notifying children's teachers	119
5.4.6	Less restrictive visitation to the ICU	119
5.4.7	Communication with men and family	120
5.4.8	Counselling	120
5.5.9	Benefits of debriefing	121
5.5.10	Future research	122
5.6	Conclusion	122
Appendix 1: Local newspaper recruitment advertisement		123
Appendix 2: RMIT media release		124
Appendix 3: Recruitment letter		125
Appendix 4: Information letter for Maternal & Child Health Nurses		126
Appendix 5: Plain language statement for research participants		127
Appendix 6: Consent form for participants		128
Appendix 7: Interview questions for participants		129
Appendix 8: RMIT University HREC approval		131
REFERENCES		132

LIST OF TABLES

Table 4.1	Birth Outcomes	39
Table 4.2	Post delivery complications	40

ABSTRACT

Naturalistic Inquiry was used to explore, describe and discover the experiences and perceptions of men whose partners have been admitted to an Intensive Care Unit (ICU) immediately after childbirth. The sixteen men's experiences were explored using semi-structured open-ended questions. Data were analysed using thematic content analysis.

The research questions driving this study were:

- What are men's experiences and perceptions of the incidence and impact of their partners being admitted to ICU following the complications of childbirth?
- What is the nature of the relationships and interactions that men have with healthcare professionals before, during and after their partner's ICU admission following the complications of childbirth?
- What impact did the experience of their partners being admitted to ICU, following the complications of childbirth, have on the men's relationships with their partners, newborn child, and other children?
- What impact did the experiences of their partners being admitted to ICU following the complications of childbirth have on their future life plans?

During the time of their partners' obstetric crisis the men, in this study, were left isolated, alone and struggling. The current healthcare policy and practice for men with their partners in life-threatening situations intrapartum and immediately postpartum failed 16 families.

Key words: Obstetric Crisis, Intensive Care, Men, Obstetric Haemorrhage, Postnatal Women.

DECLARATION

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; and, any editorial work, paid or unpaid, carried out by a third party is acknowledged.

Helen Hamilton, a professional editor, assisted the candidate with Chapter four of this thesis, in accordance with the Australian Standards for Editing Guidelines. The candidate and the professional editor worked within the guidelines established under E3 Text to minimise distractions for the reader.

Signed:

JANINE PARSONS

20 December 2007

ACKNOWLEDGEMENTS

I would like to acknowledge the supervision and support provided by my supervisors Adjunct Professor Olga Kanitsaki and Professor Megan-Jane Johnstone. I am deeply grateful for your guidance during the times I felt completely over-whelmed.

To my husband, Stephen, and my son, Sean, I thank you both for your patience, understanding, your endless love and support, and the belief that one day I would complete this thesis. I am looking forward to spending weekends with you both.

To my Mum, Dad and sisters, Tracy and Michelle, your love and support helped me enormously. Mum your phone calls were always greatly appreciated.

To my wonderful girlfriends Mandy, Bernice, Jane, Monica, Kate and Fiona thank you for listening to me during our morning walks. Your support, encouragement and interest in this research study were always appreciated.

Finally, I am indebted to the men who participated in the study, and gave so willingly of their time. Thank you for sharing your experiences with me.

AIMS AND OBJECTIVES

AIMS

- Explore men's experiences & perceptions of the incidence & impact of their partners being admitted to ICU following the complications of childbirth;
- Explore & describe the nature of the relationships & interactions that men have with healthcare staff before, during & after their partner's ICU admission;
- Discover what impact the experience of their partners being admitted to ICU, following complications of childbirth, had on men's relationships with their partners, newborn child, & other children (if any);
- Discover what impact (if any) the experiences of their partners being admitted to ICU following complications of childbirth had on their future life plans.

OBJECTIVES

- Discover what processes are used to support and involve men in the care of their partners and newborn child before, during and after their partner's ICU admission following the complications of childbirth;
- Identify any gaps that might exist in the care and support provided to the men whose partners were admitted to ICU following the complications of childbirth;
- Explore men's views on what processes they believe would best support them in the event of their partners being admitted to ICU following the complications of childbirth.

ABBREVIATIONS

AFE	Amniotic Fluid Embolism
ANZICS	Australian and New Zealand Intensive Care Society
APH	Antepartum Haemorrhage
BP	Blood Pressure
DIC	Disseminated Intravascular Coagulopathy
ECMO	Extracorporeal Membrane Oxygenation
HELLP	Haemolysis Elevated Liver enzymes and Low Platelets
ICU	Intensive Care Unit
NICU	Neonatal Intensive Care Unit
PPH	Postpartum Haemorrhage
PTSD	Post Traumatic Stress Disorder

GLOSSARY OF TERMS

For the purposes of this thesis the following key terms were used in keeping with the definitions provided below (Brown et al 2000; Figley and Kleber 1995; Beischer et al 1997).

Amniotic Fluid Embolism (AFE):

Amniotic fluid embolism is a rare obstetric emergency in which amniotic fluid, fetal cells, hair, or other debris enters the maternal circulation, causing cardiorespiratory collapse.

Antepartum Haemorrhage (APH):

Bleeding from the birth canal in excess of 15 mL in the period from the 20th week of gestation to the birth of the baby.

Extracorporeal Membrane Oxygenation (ECMO):

ECMO is used when a patient has a condition that prevents the lungs from working properly. An operation is performed to insert tubes (cannulae) into a large vein, which carries the blood to the ECMO circuit to oxygenate the blood, and back again to a large vein or artery. The ECMO circuit provides a temporary lung and allows the patient's lungs to rest and recover. The patient remains on a ventilator but all the settings will be lower than previously set, to minimise damage to the lungs.

Fundal height:

The distance between the top of a pregnant woman's uterus (called the fundus) to her pubic bone. Measured to determine fetal age.

Fetal growth retardation:

Also known as ‘small for dates.’ Birth weight below tenth percentile according to gestational age for infants born in the community concerned.

Gestation:

Gestation is the duration of a woman’s pregnancy. In the human, gestation is normally nine months.

HELLP syndrome:

Characteristic of HELLP syndrome are **H**aemolysis, **E**levated **L**iver enzymes and **L**ow **P**latelets. HELLP syndrome is a life-threatening obstetric complication considered by many to be a variant of pre-eclampsia. HELLP syndrome can occur during the later stages of pregnancy or immediately after childbirth.

Hysterectomy:

A hysterectomy is an operation to remove a woman’s uterus (womb).

Intensive Care Unit (ICU):

An intensive care unit, or ICU, is a specialized section of a hospital that provides comprehensive and continuous care for persons who are critically ill, and require 24-hour observation.

Intubate/Ventilate:

To intubate is the process where a tube is placed down someone’s throat into the trachea (windpipe); the tube is connected to a ventilator that delivers measured amounts of oxygen into the lungs (and then lets it out again) to help the person breathe.

Lochia:

The discharge from the uterus during the puerperium; it is initially red (lochia rubra) then yellow (lochia serosa) and finally white (lochia alba).

Midwife:

A person with training and professional experience who provides care to women during pregnancy and through labour and delivery. Midwives usually take a holistic and woman-focused approach to pregnancy and childbirth; many work with the backup support of a medical doctor.

Multigravida:

A multigravida woman is one who is pregnant for the second or subsequent time.

Neonatal Intensive Care Unit (NICU):

NICU is a unit of the hospital specialising in the care of ill or premature infants.

Obstetrician:

An obstetrician is a physician that specialises childbirth. An obstetrician is concerned with caring for women before, during and after childbirth.

Obstetric haemorrhage:

Also includes ante-partum haemorrhage and post-partum haemorrhage.

Oedema:

Oedema, which occurs during pregnancy, is characterised by swelling of the fingers, legs, toes and face. The increased fluid in a mother's body entering the soft tissues causes oedema.

Placenta praevia:

Placenta praevia is a complication of pregnancy, where the placenta is in the lower segment of the uterus and covers part of the entire cervix.

Pre-eclampsia:

Hypertension in pregnancy is diagnosed when the systolic blood pressure (BP) is $\geq 140\text{mmHg}$ and/or diastolic BP $\geq 90\text{mmHg}$. Gestational hypertension, hypertension arising for the first time after 20 weeks gestation, may be an isolated finding or a

multi-system disorder known as pre-eclampsia. Pre-eclampsia is clinically diagnosed when gestational hypertension exists with one of the following: proteinuria, renal insufficiency, liver disease, neurological signs or symptoms, haematological disturbances or fetal growth restriction. Eclampsia is defined as the presence of convulsions, in association with pre-eclampsia, during pregnancy or in the first 10 days of childbirth. Pre-eclampsia is diagnosed when any two of the following signs are present: hypertension (blood pressure (BP) $\geq 140/90$ mmHg), generalised oedema and proteinuria not due to infection or contamination of the urine

Postpartum Haemorrhage (PPH):

(a) Primary: blood loss in excess of 600 mL from the birth canal during the third stage of labour and for 24 hours afterwards. (b) Secondary: Bleeding occurring in the interval from 24 hours after delivery until the end of puerperium.

Post-traumatic Stress Disorder (PTSD):

‘PTSD is characterised by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with trauma’ (DSM-IV-TR 1994 p.429)

Premature infant:

An infant born before 37 completed weeks’ gestation.

Primigravida:

A primigravida woman is one who is pregnant for the first time.

Puerperium:

Puerperium is the period during which the reproductive organs return to their prepregnant condition. Usually regarded as an interval of six weeks after delivery of an infant/s.

Retained placenta:

A retained placenta is where the placenta is still in the uterus 1 hour after birth of the infant.

Singleton birth:

The baby from a pregnancy resulting in only one live or still birth.

Thrombocytopenia:

Low platelet count in the blood that increases the risk of bleeding.

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

In this chapter attention is given to providing a background to the study, outlining the scope of the inquiry, identifying the aims and related objectives of the study, and the research questions that the study has sought to address. The chapter concludes by providing a synopsis of the study's chapters.

1.2 Background to the study

In some unanticipated situations, women who have experienced medical complications immediately after childbirth require admission into an ICU. Hypertensive disorders, such as pre-eclampsia and massive obstetric haemorrhage are the two most common conditions that necessitate the majority of women, post delivery of their baby, into ICU (Lapinsky et al 1997; Pollock 2006). In such instances, the partner is placed in a situation where he must manage not only the newborn infant, and sometimes other children, but also the critical situation affecting his critically ill partner. The crisis faced by the partner is evident when he visits his critically ill partner for the first time in ICU. His reaction is often one of shock, disbelief and anxiety (Gaw-Ens 1994).

Often critical illness occurs without warning, leaving little time for family to prepare for this experience (Leske 1992). Families are thrown into a state of crisis when a member of the family is admitted into an ICU (Gaw-Ens 1994). Psychological and other forms of stress, within the family are produced through feelings of uncertainty,

fear that the patient will die, financial concerns, disruption of home routines, changes in roles within the family and the unfamiliar environment of an ICU (Simpson 1989; Leske 1992; Curry 1995). The stress that the family faces may increase over time, as they are seldom dealing with a single situation (Leske 2000).

1.2.1 Intensive care environment

Explanations about the intensive care environment, availability of resources and the condition of the patient have been identified as important information needs. Yet, it is still identified that families needs for information have not been met as well as other needs (Wesphal 1995).

The admission of an obstetric patient to an ICU leads the family members to experience emotions, such as, 'helplessness, fright, anxiety and depression' (Harvey 1992 p.721). A study by Barclay et al (1996) titled, 'Men's experiences during their partner's first pregnancy: a grounded theory analysis' concluded health services are not meeting most men's needs (p.23). A key recommendation of the study was that further studies on men could improve a system in which 'most men feel excluded, ignores and misinterprets their needs' (Barclay et al 1996 p.23).

In most cases the critically ill postpartum women recover quickly, requiring only a short length of stay in ICU. Some women do not require the full utilization of the ICUs services, such as mechanical ventilation or inotrope support (Hazelgrove et al 2001; Pollock 2006).

Pre-eclampsia and obstetric haemorrhages are the two most common conditions that necessitate the majority of women, post-delivery of their baby, admission into an ICU

(Pollock 2006). Although the ICU admission of post-natal women is not common, caring for the post-natal woman brings with it a different set of challenges due to the conditions unique to pregnancy. Despite the very different clinical requirements of these women, many of the surveys about utilisation of ICU by obstetric patients do not report on pregnant and post-natal women as sub-groups of the study population, and/or the unique experiences of this population (Lapinsky et al 1997; Mahutte et al 1999; Panchal et al 2000).

1.2.2 Maternal Deaths

Of the leading causes of maternal deaths across the world, approximately 13% is due to hypertensive disorders of pregnancy (Robson 2002). Hypertension in pregnancy includes pre-existing hypertension, gestational hypertension, pre-eclampsia, eclampsia and Haemolysis Elevated Liver enzymes and Low Platelets (HELLP) syndrome, a variant of pre-eclampsia (Brown et al 2000). Hypertension in pregnancy is diagnosed when the systolic Blood Pressure (BP) is $\geq 140\text{mmHg}$ and/or diastolic BP $\geq 90\text{mmHg}$ (Brown et al 2000). Gestational hypertension, hypertension arising for the first time after 20 weeks gestation, may be an isolated finding or a multi-system disorder known as pre-eclampsia. Pre-eclampsia is clinically diagnosed when gestational hypertension exists with one of the following: proteinuria, renal insufficiency, liver disease, neurological signs or symptoms, haematological disturbances or fetal growth restriction. Eclampsia is defined as the presence of convulsions, in association with pre-eclampsia, during pregnancy or in the first 10 days of childbirth (Robson 2002). Women have died having progressed to eclampsia, due to intracranial haemorrhage followed by adult respiratory distress syndrome and further multi-system failure (Robson 2002).

The HELLP syndrome is a type of pre-eclampsia, although hypertension is not always present (Rath et al 2000). HELLP syndrome is diagnosed when three of the following criteria exist: Haemolysis, Elevated Liver enzymes and a Low Platelet count, hence the acronym HELLP. This condition often occurs during the third trimester of pregnancy and always necessitates the delivery of the baby. Resuscitation of the women with blood products and correction of the inevitable coagulopathy are pre-eminent components in management. This syndrome requires continuous high-grade care of the postpartum women, as resolution is often delayed over many days, due to thrombocytopaenia, liver abnormalities, hypertension, and some cases of renal failure. Approximately one third of women with eclampsia present in the post-natal period with 80% of these women fitting 48 hours after delivery (Chames et al 2002).

The Australian Institute of Health and Welfare (AIHW) database reported that for every death related to variant forms of pre-eclampsia ‘there are hundreds of cases of severe morbidity, with complications requiring intensive care’ (AIHW 2006). Gaining control of high BP is a not only a priority to help minimise the risk of cerebral haemorrhage, which is a documented risk of hypertension in pre-eclampsia, but to also improve organ perfusion. Hypertension in postpartum women admitted into ICU is managed by using anti-hypertensive agents, although this varies depending on what the healthcare professionals are most familiar with (Duley and Henderson-Smart 2001). Other supportive measures that ICU offers to these women to protect from organ failure, which can occur due to vasospasm and decreased organ perfusion, are the administration of plasma volume expanders, corticosteroids and anticonvulsant therapy (Duley and Henderson-Smart 2001).

In Australia obstetric haemorrhage is the principal cause of maternal mortality as it can be sudden and unpredictable (Sullivan et al 2004). Obstetric haemorrhage includes Antepartum Haemorrhage (APH) and Postpartum Haemorrhage (PPH), the latter the major cause of maternal death (Schurmans et al 2002). These women are admitted to ICU having experienced a dramatic loss of blood, which requires reversal of coagulopathy and haemodynamic stabilisation (Lapinsky et al 1997). Severe PPH can lead to the women developing disseminated intravascular coagulopathy (DIC) which requires specific blood products. In a recent study commissioned by the Victorian Consultative Council on Obstetric and Paediatric Morbidity and Mortality it was reported that PPH in Victoria for 2002 was 9.5% which is an increase of more than 3% over that figure for the last decade, which was 6.2%. In Victoria of all pregnant women the hysterectomy rate associated with PPH has increased from 0.03% in 1999 to 0.08% in 2002. In all cases the hysterectomy was an emergency life saving operation to treat the PPH, and often required admission to ICU. Between the years of 2000-2002 five women had PPH as the principal cause of death (AIHW 2006).

1.2.3 Breast Feeding

When a woman is admitted into an ICU immediately after childbirth it presents a new set of challenges to the critical care nurses who will be looking after her. Often the critical care nurse in attendance does not have a midwifery qualification, and does not have the knowledge skills to assess the postpartum women's breasts, height of fundus or colour of lochia.

When a post-natal women is admitted to ICU, although it is not a priority, it is important to identify what choice she has made regarding feeding her newborn infant. Arora et al (2000) state that most women, prior to becoming pregnant or during the first trimester of pregnancy, have decided how they are going to feed their infant. After delivery a women's milk 'comes in' between 3-4 days (Neville et al 1988). To assist milk to 'come in' expressing 2-3 hourly should begin within 24 hours of delivery (Meier 2001). Hand expressing is recommended for the first few days until the milk 'comes in', as the use of breast pumps can generate high pressures and cause nipple damage (James 2004). Within the setting of a maternal critical illness there have been no papers published regarding the establishment of lactation to guide the healthcare professionals.

1.2.4 Stress of impending fatherhood

During the past 40 years, healthcare providers and childbirth educators have enhanced expectant fathers' experiences of childbirth by informing couples of alternative labour roles that the expectant father can assume. Expectant couples have assumed more responsibility during the labour and the birthing process, even though fathers view this as very stressful and are concerned about their role of labour coach (Chapman 1991 p.114). It has been observed that during the first year following an infant's birth the father's health and general well being declines (Ferketich and Mercer 1989). If fathers are already stressed with the thought of impending fatherhood this is compounded when their partner experiences complications, during or immediately after childbirth, which requires her to be transferred into ICU.

1.2.5 Obstetric patients in ICU

A search of multiple electronic databases (eg: PubMed, Medline, CINAHL, and Scholargoogle) using keywords, such as, intensive care, critical care, men, relatives, family, visiting, post-natal complications, obstetric haemorrhage, postpartum haemorrhage, PPH, postpartum bleeding, pregnancy complications, amniotic fluid embolism and maternal mortality failed to locate any published studies specifically investigating men whose partners were admitted into an ICU immediately after childbirth in the cultural context of Australia.

There are numerous studies (too numerous to list here) on relatives who have a family member in ICU, but not specifically on men who partners have been admitted into an ICU immediately after childbirth. There are, also, numerous studies investigating obstetric conditions and treatments but these have been conducted in obstetric settings, not in the ICU.

In the United States of America (USA) women who suffer an obstetric crisis can be admitted to a special obstetric ICU to be cared for by qualified midwifery and intensive care staff (Mabie and Sibai 1990; Lapinsky 1998). In Australia there are no such facilities, critically ill post-natal women are admitted into a general ICU.

It is expected that obstetric admissions to ICU will be more prevalent in the future due to the increasing age of mothers in Australia (Slaytor et al 2004). The average age of all women giving birth in 2004 was 31 years, up from 30.2 years in 2002 and 27.6 in 1986 (AIHW 2006). The incidence of pre-eclampsia and associated morbidity increases in women over the age of 35 (Zhang et al 2003), and it is probable that

severe obstetric haemorrhage will continue to climb with the increase in interventions such, as induction of labour and caesarean section (Haynes et al 2004).

1.2.6 ICU obstetric patient data

Australia, like other countries around the world, has no reliable data regarding obstetric admissions to ICU. Australian and New Zealand Intensive Care Society (ANZICS) maintain a national registry of descriptors of public hospital ICUs, which includes patient's diagnosis and length of stay. The ANZICS database does not define identification of the types of pregnant women admitted in ICU. All obstetric patients admitted to ICU are coded as 'pregnancy related', therefore data pertaining specifically to postpartum ICU admissions is not collected. Of the 62,543 confinements in 2004 there were 13 maternal deaths, compared with 2 in 2003 and seven in 2002. The AIHW database states of these 13 maternal deaths, ““There were four direct, six indirect and 3 incidental maternal deaths”” (AIHW 2006).

The literature search conducted in the context of this study has also failed to locate any published studies that explore men's experiences and perceptions of the incidence and impact of their partners being admitted into and ICU following the complications of childbirth. Understanding men's personal experiences of their partner's admission into an ICU can assist healthcare professionals to use supportive processes to ensure that men will be supported during their partner's admission to an ICU. It is envisaged that this research will provide insights and deep understanding that can assist healthcare professionals to provide the best care for the men, partners and newborn infant before, during and after their partners ICU admission following the

complications of childbirth. An important aim of this study is to redress this knowledge gap.

1.3 Scope of the study

This study has as its focus men's experiences and perceptions of the incidence and impact of their partners being admitted to an ICU immediately after childbirth. The men's partners were admitted to a maternity hospital to give birth to their infant and in all cases the women were transferred to an ICU either in the same hospital or another hospital with an ICU. The study was conducted across seven metropolitan hospitals (Six maternity hospitals, three of which had ICUs and one metropolitan teaching hospital). 16 men participated in the study. All of the men's partner's had singleton live deliveries. Nine of the men's partners were transferred to an ICU within the hospital in which they gave birth and seven of the men's partners were transferred to an ICU in another hospital. During this time 14 of the newborn infants remained in the maternity hospital where they were born and 2 newborn infants were transferred to a specialised metropolitan Melbourne Neonatal Intensive Care Unit (NICU).

A Naturalistic Inquiry approach was chosen as it was considered the most appropriate for the purposes of exploring and describing the phenomenon chosen for this study; that is, the experiences of men whose partners have been admitted to ICU immediately after childbirth. Data were collected via semi-structured conversational style interviews using open-ended questions. Data were analysed using content and thematic analysis strategies.

1.4 Research aims

The aims of this research were to:

- Explore men's experiences and perceptions of the incidence and impact of their partners being admitted to an Intensive Care Unit (ICU) following the complications of childbirth;
- Explore and describe the nature of the relationships and interactions that men have with healthcare professionals before, during and after their partner's ICU admission following the complications of childbirth;
- Discover what impact the experience of their partners being admitted to ICU following the complications of childbirth had on the men's relationships with their partners, newborn child, and other children;
- Discover what impact the experiences of their partners being admitted to ICU following the complications of childbirth had on their future life plans.

Related objectives of this study were to:

- Discover what processes are used to support and involve men in the care of their partners and newborn child before, during and after their partner's ICU admission following the complications of childbirth;
- Identify any gaps that might exist in the care and support provided to the men whose partners were admitted to ICU following the complications of childbirth;
- Explore men's views on what processes they believe would best support them in the event of their partners being admitted to ICU following the complications of childbirth.

1.5 Research questions

The research questions driving this study were:

- What are men's experiences and perceptions of the incidence and impact of their partners being admitted to ICU following the complications of childbirth?
- What is the nature of the relationships and interactions that men have with healthcare professionals before, during and after their partner's ICU admission following the complications of childbirth?
- What impact did the experience of their partners being admitted to ICU following the complications of childbirth have on the men's relationships with their partners, newborn child, and other children?
- What impact did the experiences of their partners being admitted to ICU following the complications of childbirth have on their future life plans?

1.6 Synopsis of chapters

Chapter One is the Introduction in which a brief background and scope of the study is provided. Chapter Two provides a review of the literature pertinent to the inquiry. Chapter Three presents an overview of the Naturalistic research method used to advance this study and the reasons for its selection. Sample selection; data collection and analysis; presentation and dissemination of the research findings; and the processes implemented for ensuring research rigour and the credibility of the research findings are also described. Limitations of the study, ethics approval processes, and other matters arising in the framework of this study are also considered in this chapter. Chapter Four focuses on analysis and presentation of the data. In Chapter

Five, the concluding chapter of this thesis are the discussion of the research findings, and related recommendations are presented.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter has as its focus a review of the literature on the complications women suffer after childbirth that warrant their admission into an ICU, the various role changes that occur within the family dynamics during this time and issues arising when relatives, especially their partner, visit their ‘loved one’ in an ICU.

2.2 Complications after childbirth

In some unanticipated situations, women who have experienced obstetric complications immediately after childbirth require admission into ICU. Excessive blood loss, a reaction to medication given during labour and high blood pressure are some of the complications that may warrant admission into an ICU (Hazelgrove et al 2001; Demirkiran et al 2003; Pollock 2006).

In most cases the obstetric patient is often young and healthy. Most admissions of the obstetric patient occur in the low risk pregnancies without a contributory obstetric history (Zeeman 2006). However, the potential for ‘catastrophic complications’ is a reality, and although, over the decades there have been therapeutic and medical advances maternal morbidity and mortality still occur (Zeeman 2006 p.S208). A serious medical condition requiring admission into an ICU is a potential crisis situation not only for the obstetric patient but also for her partner who is placed in a situation where he must manage not only the newborn infant, and possibly other children, but also the situation affecting his critically ill partner.

2.3 The waiting room

Molter (1979) in the late 1970s developed the Critical Care Family Needs Inventory based on the needs and concerns of relatives of critically ill patients. The findings of this study revealed five most important needs of the relatives of critically ill patients; these were:

- to feel there is hope;
- to feel that hospital personnel care about the patient;
- to have the waiting room near the patient;
- to be called at home about the changes in the condition of the patient; and
- to be informed about the patient's prognosis (Molter, 1979).

Leske (1986) developed an 'intensive care family needs' inventory based on Molter's (1979) study. Many other studies have been conducted replicating Molter's themes and have identified more needs of relatives of critically ill notably the need for hope, meaning and resilience, and for a supportive environment to counter the shock and uncertainty of illness (Wilkinson 1995; Rose 1995; Plowfield 1999; Bournes and Mitchell 2002).

Kutash and Northrop's (2007) study found that relatives of critically ill patients spoke about the intensive care waiting room in a 'negative context' (p.387). For example, in the intensive care waiting room, furniture was pushed closely together and was too uncomfortable to sit in. Relatives in Kutash and Northrop's (2007) study wanted the hospital personnel to check in on them to make sure they were 'comfortable', being supplied with enough water, and clean blankets. Also being in close proximity to the critically ill patient was important as this enabled the hospital staff to give information to the relative through 'face-to-face communication at anytime' (Leske 1986; Lee and

Lau 2003). Family needed and wanted ‘to be informed of any change in the patient’s status’ (Kutash and Northrop 2007 p.388).

The intensive care waiting room serves as a pivotal place where family members received emotional support from others who were in similar situations as themselves (Kutash and Northrop 2007). Rogers (1983) observed that relatives of critically ill patients formed a community of strangers linked together by a common experience. Some relatives felt a sense of closeness and gained strength through other relatives who shared the same experience (Bournes and Mitchell 2002).

Within the walls of the intensive care waiting room the family of the critically ill patient experienced a ‘roller coaster’ of emotions (Kutash and Northrop 2007 p. 387). In the study conducted by Kutash and Northrop (2007), some of the descriptive words used by the relatives to describe their emotions when they had a loved one in the ICU were ‘shock’, ‘hope’, ‘uncertainty’ and ‘relief’ (p.387).

Some studies use the term ‘loved one’ to identify significant others who are important to the patient (Eriksson and Bergbom 2007; Robb 1998). ‘Loved ones’ are defined as ‘persons in the patient’s social network who are important and significant for them and with whom they have a positive emotional relationship’ (Eriksson and Bergbom 2007 p.20). These ‘significant others’ may be a spouse, children, partner, friends or neighbour. Robb (1998) identified that the most important factor is that the patient describes them as ‘loved ones.’

2.4 Visitation in the ICU

Despite evidence that is supportive regarding the benefits of flexible or ‘open visiting’ in the ICU, current practices do not reflect this (Kutash and Northrop 2007 p.384).

Visiting hours are still a controversial topic amongst healthcare professionals. It appears that visitation in ICU is based on practices initiated when these units were first opened in the 1960's (Cullen et al 2003). During this time, the 1960s, visitation was restricted as very little was known about the impact on the patient or family members, including children (Cullen et al 2003). Cullen et al (2003) state that, 'Research has demonstrated that rigid and restrictive visitation should be abolished, and may actually be harmful to the patient, family members and family dynamics' (p.62). The positive effects of family members' interactions with critically patients include better family understanding of the patient's illness, patient and family anxiety is reduced and helped improve rests between visits (Lazure and Baun 1995; Henneman et al 1992; Cullen et al 2003). Increasing family visitation to the critically ill patient enhances family satisfaction as it has the opportunity to meet more of their needs and increases the family member's satisfaction with the intensive care experience (Freismuth 1986; Cullen et al 2003). Less restrictive visitation of the critically ill appears to have a positive impact on the family members and 'outweighs the potentially negative consequences' (Cullen et al 2003 p.62). Although, intensive care nurses still believe that open visitation in the ICU causes delays and interferes with the provision of adequate patient care (Cullen et al 2003).

However, a study by Kirchhoff et al (1993) highlighted intensive care nurses believed the consequences of visiting was more positive for the patient from a psychological point of view but not a physiological perspective. The nurses participating in this study also believed that visiting had negative consequences on the family as they became exhausted, and that visiting was disruptive for nursing care delivery. The nurses stated that the visiting family made it difficult for them to

concentrate and feel in 'control' of the situation, and 'created chaos' and 'traffic' and caused 'delays' in nursing care because more time was spent talking to family and less time for the patient (Kirchhoff et al 1993 p.241). Families may be seen as 'outsiders' in a fast paced technological environment that is often overcrowded and understaffed (Kirchhoff et al 1993). In the study by Kirchhoff et al (1993) they state that it is important for family members to participate in patient care during hospitalisation due to current shortened length of hospital stay and therefore, the subsequent need for the family to provide care after discharge.

Eriksson and Bergbom's (2007) study identified that the most frequent visitors to the ICU were spouses and children (p.20). The 'loved ones' were seen by the critically ill patient to be more important than the professional carers (Eriksson and Bergbom 2007 p.21). The critically ill patient found that the presence of a 'loved one' assisted their battle against illness or injury as they conveyed to them hope and strength and kept them in touch with reality. In a study by Maddox et al (2001) the patients who survived their critical illness described their love for their partner since their illness had become closer and deeper, and thought of their partner as their 'lifeline' (p.6).

2.5 Informational needs of the critically ill patient's family

Henneman et al (1992) stated that the 'fast pace' and 'heavy workload' of the intensive care environment was often seen, by the family of the critically ill patient, as a barrier to the healthcare professional's ability to effectively meet the informational needs of the critically ill patient's family (p.85).

2.6 Caring for the obstetric patient in ICU

In some cases women, who have just given birth, require the technological support of an ICU. Although the ICU admission of post-natal women is not common, caring for the post-natal woman in ICU brings with it a different set of challenges due to the conditions unique to pregnancy. Generally, for most postpartum patients there is a fast recovery following treatment of the initial insult warranting their admission to ICU (Pollock 2006).

Most critically ill postpartum women recover quickly requiring only a short length of stay of less than 48 hours in ICU, which is shorter than the mean length of stay in the non-obstetric patient (Reynolds and Laurence 1997; Hazelgrove et al 2001; Pollock 2006). Some women do not need the full utilization of the ICU services, such as mechanical ventilation or inotrope support (Hazelgrove et al 2001). However, in some cases, the women who experience complications after childbirth require medical intervention and treatment on a multidisciplinary basis, which requires an ICU admission for support on a ventilator, invasive monitoring and vasoactive drugs to alleviate progression of organ dysfunction and improve their prognosis (Zeeman 2006).

For the family unit the admission of a 'loved one' into the intensive care environment can represent a serious disruption to the everyday activities and also risk changing the integrity and structure to the family unit. The crisis faced by the men is evident when they visit their critically ill postpartum partners in the ICU. The men when visiting their partner, who has been admitted to ICU after complications suffered after childbirth, appear visibly distressed and overwhelmed by the magnitude of the machinery and technology that is required to keep their partner alive. The men's

reaction is often one of ‘shock, disbelief and anxiety’ (Gaw-Ens 1994 p.41). The intensive care nurse has an important role in the management and support of the critically ill patient’s family as well as the patient (Schlump-Urguhart 1990; Freichels 1991). However, with the exception of Harvey (1992), very little research is available that has examined the responsibility that the healthcare professional has toward the ICU postpartum patient’s partner.

2.7 Physiological changes during pregnancy

In most cases pregnancy and childbirth is a natural, uncomplicated process. During pregnancy each system in the woman’s body undergoes various forms of physiological change. The major physiological changes that take place in a woman’s body during pregnancy are the uterus enlarges to give nourishment and protection to a growing fetus. From the eighth week of pregnancy there is an increase of 40-50% in blood volume, mainly in the plasma, but only a slight increase in the red cells. Due to the haemodilution, red cell counts and haemoglobin estimations can be 10-15% lower during pregnancy. This increase in blood volume needs to be pumped by the heart with sufficient force to maintain an adequate placental circulation, so the cardiac output¹ is increased by 40-50% and remains elevated until delivery. The lungs are displaced slightly upwards and the growing uterus impinges on the thorax and restricts the free movement of the diaphragm. The woman may experience shortness of breath due to deeper respirations, which are necessary because of increased oxygen consumption (Beischer et al 1997).

Diagnosis of the presence and type of anaemia is important during pregnancy, since, if overlooked, the morbidity and mortality of both mother and fetus are increased due

¹ The traditional measure of heart function

to inability to withstand haemorrhage, susceptibility to infection, cardiac failure, premature labour, fetal hypoxia and growth retardation (Beischer et al 1997).

During pregnancy there is an increase in some of the coagulation factors, which tend to protect the mother from the inevitable bleeding which occurs at delivery. This increase, in some of the coagulation factors, can also increase the risk of thromboembolism especially in the puerperium².

2.8 Births and maternal mortality

Although childbirth is a normal process, it is not risk free. According to AHIW (2006) between the years 2000-2002 the number of women who gave birth was 753,901, an average of 251,300 women who gave birth per year. The maternal mortality ratio for direct deaths was 4.2 deaths per 100,000 women who gave birth in the 2000-2002 triennium. This equates to 32 maternal deaths in a 3 year period in Australia. The causes of direct death were amniotic fluid embolism³ (n=10), obstetric haemorrhage⁴ (n=9), infection (n=5), hypertensive disorders of pregnancy⁵ (n=4), pulmonary

² The time in which the reproductive organs return to their pre-pregnant condition – often regarded as an interval of 6 weeks post delivery.

³ Entry of amniotic fluid into the maternal venous circulation.

⁴ Includes:

- Antepartum haemorrhage (APH) $\geq 15\text{mL}$ of bleeding from the birth canal from the 20th week of gestation to the birth of the baby.
- Postpartum haemorrhage (PPH). Primary PPH $\geq 600\text{mL}$ from the birth canal during the third stage and the immediate 24 hours afterwards. Secondary PPH-bleeding that occurs from the birth canal after 24 hours of birth until the end of puerperium.
- Placenta percreta – chorionic villi are through the uterine muscle wall (a type of uterine rupture).
- Abruptio placentae (accidental haemorrhage) – bleeding from a normally situated placenta causing its partial or complete detachment after the 20th week gestation.

⁵ -Hypertension in pregnancy - Systolic BP $\geq 140\text{mmHg}$ and/or a diastolic $\geq 90\text{mmHg}$

-Essential hypertension – Hypertension in the first 20 weeks or that pre-existed to pregnancy.

-Gestational hypertension – Hypertension presenting after 20 weeks gestation and resolving by 3 months post partum and no evidence of preeclampsia.

-Preeclampsia – Hypertension presenting after 20 weeks gestation and including one or more of following:

- Proteinuria: $\geq 300\text{mg}/24\text{hours}$
- Renal insufficiency: oliguria or serum/plasma $\geq 0.09\text{mmol/L}$

thromboembolism⁶ (n=2), ruptured ectopic pregnancy⁷ (n=1) and one death due to anaesthesia⁸ (AIHW 2006).

During the year of 2005 information collected from participating hospitals Australia wide and sent to the ANZICS Database displayed that of total of 83,813 patients were admitted into ICU. Of these 366 women, classified as pregnancy related, preeclampsia or PPH, were admitted into ICU. Of the 366 women admitted into ICU, two died in hospital (mean age 31 years old, and mean length of stay in hospital was 32 days). Despite the very different clinical requirements of these antenatal and postnatal women, many of the surveys about utilisation of ICU by obstetric patients do not report on pregnant and postnatal women as sub-groups of the study population (Lapinsky et al 1997; Mahutte et al 1999; Panchal et al 2000).

There is little known about social and emotional experiences of men during their partner's admission to an ICU. Most literature has focused on the needs of the critically ill patient's family (Coulter 1989; Arkley 1990; Burke and Nagle 1993; Jamerson et al 1996; Curry 1995). A search of multiple electronic databases, such as, PubMed, Medline, CINAHL and Scholargoogle were unable to locate articles specifically related to the men's needs while their partner is in ICU after childbirth.

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- Liver disease: raised serum transaminases
 - Neurological problems: convulsions, hyperreflexia with clonus, severe headaches with hyperreflexia, persistent visual disturbances.
 - Haematological disturbances: disseminated intravascular coagulation (DIC), haemolysis, thrombocytopaenia.
 - Fetal growth restriction (Brown et al 2000; Beischer and MacKay 1986)

-Eclampsia – a type of severe preeclampsia with generalised seizures, not caused by epilepsy or other disease and occurring ≥ 20 weeks gestation, during labour or postpartum.

-Haemolysis Elevated Liver enzymes and Low Platelets (HELLP) syndrome:

- A type of severe preeclampsia, hypertension may not be present
- Diagnosis is made in the presence of 3 following criteria
 - Haemolysis
 - Elevated liver enzymes
 - Low platelet count (Brown et al 2000)

⁶ Occlusion of the major arteries to the lungs from a large detached blood clot

⁷ Implantation of the fertilised ovum outside the uterus. The fallopian tube is the commonest site.

⁸ Epidural abscess

Other studies regarding men centre on men becoming fathers or their roles during birth and after birth. For example, Kaila-Behm and Vehvilainen-Julkunen's (1997) study, 'From man to father-a review of nursing research,' and Hall's (1994) study, 'From fun and excitement to joy and trouble: an explorative study of three Danish fathers' experiences around birth'. There have been studies of obstetric patients in ICU, however these have not focused on specific men's needs, for example a study by Harvey (1992) 'Promoting parenting: the obstetric patient in an intensive care unit' and a study by Shailer and Harvey (1992) on the 'Management of the intrapartum patient in the intensive care unit: preparing for delivery.'

Research has identified that unexpected hospitalisation after trauma has significant impact on family members (Leske 2000). Extrapolating from these studies it is understandable that the admission of a partner to ICU immediately after childbirth could have an overwhelming affect on all the members of the family, as individuals and on the family as a whole. There is considerable scope to suggest that during this time men must deal with a variety of stressors, including worry about their partners, isolation from other children and family members, financial worries and role changes as well as the uncertain environment of the ICU (Leske 2000).

2.9 Non-parent to parent

The transition from non-parent to parent can constitute a crisis situation for the majority of first-time parents (Henderson and Brouse 1991; Nystrom and Ohrling 2004) conducted a review of 33 articles specifically aimed at describing mothers' and fathers' experiences of parenthood during the child's first year. In the studies Nystrom and Ohrling (2004) analysed:

'Mothers' experiences of being primarily responsible for the infant were expressed predominantly as feelings of powerlessness, insufficiency, guilt, loss, exhaustion, ambivalence, resentment and anger. These experiences were overwhelming and caused strain, and led to feelings of being fatigued and drained of physical and emotional energy' (p.327).

Fathers, on the other hand, experienced feelings of 'frustration, role strain, confusion, lack of confidence and tiredness' (Nystrom and Ohrling 2004 p.327). A man typically turns to his partner for emotional support after the birth of an infant (Goodman 2004). In the unanticipated situations where women who have experienced complications after childbirth and require admission to ICU they are unable to care for their newborn infant or give emotional support to their partner.

2.10 Postpartum woman in ICU

When a woman is admitted into an ICU immediately after childbirth it presents a new set of challenges to the intensive care nurses who will be looking after her (Pollock 2006). In addition to requiring general ICU nursing care postpartum women also require midwifery care to ensure good postpartum outcomes. Often, in ICU, there is no intensive care nurse on duty that has midwifery qualifications and the healthcare professionals are unable to competently monitor the postpartum woman accurately (Pollock 2006). The postpartum woman needs fundus height, lochia and breasts checked regularly (Harvey 1992; Pollock 2006).

Most intensive care nurses are competent in meeting the physiological needs of the critically ill patient but are challenged when trying to assist their, and their family's, psychosocial needs (Cullen et al 2003). In a study conducted by Hickey and Lewandowski (1988), they found that one third of intensive care nurses said that they did not have the necessary skills required to attend to the emotional and psychosocial

needs of the critically ill patient's family members. Typically, nurses receive extremely little education with regard to meeting family needs (Cullen et al 2003). A School of Nursing Senior Lecturer at one of Melbourne University's stated that the majority of Victorian postgraduate critical care courses offer a 1 or 2-hour lecture on caring for the obstetric patient in ICU.

In many cases the critically ill postpartum woman who requires an ICU admission needs to be transferred out of the maternity hospital to a larger tertiary hospital's ICU. Anecdotal evidence has shown that in the majority of cases the newborn infant remains in the maternity hospital while the mother is transferred to an ICU in another hospital. Informational observation revealed that in the majority of cases, the newborn infant is not brought over to visit the mother due to the logistics required. The woman and her newborn infant are usually reunited when the woman is well enough to be transferred back to the maternity hospital.

Hypertensive disorders, such as pre-eclampsia and massive obstetric haemorrhage are the two most common conditions that necessitate the majority of women, post delivery of their baby, into ICU (Lapinsky et al 1997; Pollock 2006). Timely delivery and prompt initiation of antihypertensive therapy for severe hypertension form the main stay of care in pre-eclampsia. Restoration of circulating blood volume and rapid control of bleeding and impaired coagulation are the main factors in the management of 'massive obstetric haemorrhage' (Zeeman 2006 p.S206).

During the past 40 years healthcare providers and childbirth educators have enhanced expectant father's experience of childbirth by informing couples of alternative labour roles that the expectant father can assume. Expectant couples have assumed more

responsibility during the labour and the birthing process, even though fathers view this as very stressful and are concerned about their role of labour coach (Chapman 1991). It has been observed that during the first year following an infant's birth the father's health and general well being declines (Ferketich and Mercer 1989). If fathers are already stressed with the thought of impending fatherhood, this is compounded when their partner experiences of birthing complications during or immediately after childbirth, which requires her to be transferred into ICU.

Explanations about the intensive care environment, availability of resources, and the condition of the ICU patient have been identified as important information needs. Yet, it is still identified that families' needs for information have not been met as well as other needs (Wesphal 1995). Factors contributing to breakdown in communication between healthcare professionals include the intensive care environment, lack of understanding, problems relating to visiting partner, separation from partner, nature of ICU practice, lack of communication, coping mechanisms and the philosophy of healthcare professionals towards the family (Cullen et al 2003).

2.11 Tumultuous time for the men

It is a tumultuous time for the partner of the critically ill women who has been admitted to an ICU immediately after childbirth. He is faced with major changes in responsibilities while his partner is in ICU. There are major concerns that can pull the man in different directions, one requiring him to remain at the bedside of his partner or newborn infant, and the other requiring him to handle additional or new responsibilities at home (Hupcey and Penrod 2000). There are also additional concerns regarding finances and his job. For the individual family member, especially the spouse, the admission of a partner into ICU can be an intensely personal and

frightening experience. The stress can trigger significant psychological trauma in men whose partners are in ICU and the outcomes of their partners are unknown. Research has demonstrated that family member's behavioural responses to a critical illness can include feelings of helplessness, anxiety and anger (Leske 2000). Family members of critically ill patients reported sleep disturbances, poorer nutrition intake, and an increased use of tobacco, alcohol and prescription medications (Halm et al 1993).

2.12 Family roles and responsibilities

While studies have described the impact of an intensive care hospitalisation on family members there has been little research conducted concerning effects of a critical illness specifically on family roles and responsibilities. The stressful experience of the admission of a family member into an ICU leads to conflicts in family roles and responsibilities and disrupts the normal home routines (Johnson et al 1995). Family members of the critically ill felt frustrated and this led to conflict as they tried to juggle work commitments, home duties and visitation to ICU (Titler et al 1991; Johnson et al 1995). Family members were also required to take on the duties formerly attended to by the critically ill which lead to an increase in the weight of responsibility already faced by family. As a consequence of an absent family member, due to their admission to an ICU, the other family members' roles changed to meet both physical household tasks and emotional needs of others. More studies are required so that the healthcare professionals looking after the critically ill patient's family can better determine and implement interventions to assist these families.

2. 13 Psychological trauma

According to the Diagnostics Statistical Manual of Mental Disorders (DSM-IV 1994), a traumatic event has a number of characteristics. It happens suddenly and unexpectedly, it disrupts one's sense of control, beliefs, values and one's basic assumptions about the world and others (DSM 1994). The stressor is usually experienced with intensity, terror and helplessness. There may be the perception of life-threatening danger, with physical and emotional symptoms. The person, in the immediate stage after the traumatic event, may experience numbness, emotional release, express relief, anger, loss and concern, experience hyper arousal and intrusion of trauma stimuli (DSM-IV 1994). As a result of the perceived trauma, the person may sense a loss of control over the traumatic event. After the traumatic event the person may experience symptoms, such as, flashbacks, nightmares, numbness, irritability, sleep disturbances, anger, being easily startled, hypervigilance, avoidance of reminders of the traumatic event, panic attacks and physiological reminders of the traumatic experience (DSM-IV 1994).

The effect of birth trauma on the partner has not been considered widely in the literature. There is little recognition that men witness the pain and suffering of their partner and are confronted with a frightening experience, which can potentially result in them being traumatised. A study by DiMatteo et al (1993) found that while some husbands were supportive of their partner during childbirth, some husbands had no experience with the medical environment and were distracted, upset, and terrified to see their partners in pain. DiMatteo et al (1993) reported that some husbands who witnessed their partner's long and arduous labour found it hard to remain focused and supportive particularly when the healthcare professionals were required to use emergency obstetric procedures.

2.14 Secondary trauma

The long term consequences on men's mental health have not been explored when men's partners have suffered complications after childbirth and been admitted to ICU. For the men who have witnessed their partner's pain and suffering during and after labour it is a confronting frightening experience and they too can be traumatised. In a study by Figley and Kleber (1995) they found that when an individual witnesses another person suffering they experience emotional responses similar to that person's actual or anticipated emotions. Secondary traumatic stress disorder is created by exposure to, and out of concern for, an individual witnessing and experiencing primary traumatic stress (Figley 1986). This type of 'secondary trauma' might dispute basic assumptions held by an individual, resulting in feelings of powerlessness, and cause the individual to question beliefs about one's self and the world.

2.15 CONCLUSION

This chapter has had as its focus a review of the literature on the complications women suffer after childbirth that warrant their admission into an ICU, the various role changes that occur within the family dynamics during this time and issues arising when relatives, especially their partner, visit their 'loved one' in an ICU. Due to limitations imposed by lack of time and funding, it has not been possible to provide a comprehensive and critical discussion of the many issues raised in and by the literature considered in the context of this thesis. The literature review as it stands is, however, adequate for the purpose of outlining the discussion of the findings of this study, to be presented in Chapter Four of this thesis.

CHAPTER THREE

METHODOLOGY AND METHOD

3.1 INTRODUCTION

This chapter has as its focus a discussion of the methodology chosen for this study. Firstly, consideration is given to describing Naturalistic Inquiry and its philosophic underpinnings. Consideration is then given to describing the processes taken to advance the study, such as, sample selection, data collection and analysis, presentation and dissemination of the study findings, as well as, processes used to ensure validity and trustworthiness of the research findings. In conclusion, consideration is given to the limitations of the study and steps taken to obtain ethical approval.

3.2 Methodology

All qualitative research should take in to account three philosophical concepts – ontology, epistemology and methodology (Denzin and Lincoln 1994). In qualitative research, links between these three concepts must be coherent to achieve internal consistency and logic (Parse 2001). Ontological issues within research mean asking oneself reflective questions about ‘What is the nature of reality?’ (Denzin and Lincoln 1994 p.13). Epistemology issues within research means asking oneself reflective questions about the relationship between the knower and the known, such as ‘What does it mean to know?’ ‘What kind of knowledge is possible?’ The choice of method and methodology is dependent on the researcher’s views of the nature of the knowledge. The methodological question being ‘How can the knower go about

finding out whatever he or she believes can be known?’ (Denzin and Lincoln 1998 p.200).

Lincoln and Guba (1985) state that ontological assumptions refer to the form and nature of ‘reality’ and ‘the study of being.’ Epistemology refers to claims as to how knowledge about this ‘reality’ may be gained by the researcher. There is a view from the perspective of Naturalistic Inquiry that there is no one true or ‘objective’ reality, but multiple realities that are subjectively recognised and create meaning for the individual.

Lincoln and Guba (1985) explain that reality is a construct in the mind of individuals and there are ‘always an infinite number of constructs that might be made and hence there are multiple realities’ (p.83). Meanings, understanding, a ‘reality’ is subjective and understood (constructed) differently by different individuals (constructors), as reality is fixed firmly in the meanings that are constructed and associated to general everyday life of each individual (Lincoln and Guba 1985).

Naturalistic Inquiry was selected to advance this study since the approach was considered to be both pragmatic and most appropriate for the purposes of exploring the phenomenon selected for this study, which is, the experience of men whose partners have been admitted to an ICU immediately after childbirth. Patton (2002) explains that to be pragmatic is to allow one to ‘eschew methodological orthodoxy in favour of methodological appropriateness as the primary criterion for judging methodological quality, recognising that different methods are appropriate for different situations’ (p.72). The most appropriate method is reliant on the phenomena

being explored and it is important to match the research methods to the aims of the study, the questions being asked and the resource availability (Patton 2002).

Patton (2002) states that a 'pragmatic and utilitarian framework can guide qualitative inquir[ies] on their practical and applied underpinning without having to be attached to or derived from a theoretical tradition' (p.145). Patton continues to state that while a phenomenon could be investigated using a phenomenological, ethnographic or heuristic approach, the researcher could conduct interviews and collect observational data to explore a phenomenon 'without working explicitly with a particular theoretical paradigmatic, or philosophical perspective.' Patton (2002) argues that not all research needs to be framed by a 'grand theory' and supports the use of 'atheoretical' methods (p.135). Employing the general strategies of qualitative research can be implemented effectively to access and analyse data and to inform recommendations for practical modifications in the world, as long as the strategies are applied rigorously.

3.2.1 Philosophic underpinnings of Naturalistic Inquiry

Naturalistic Inquiry is situated in the qualitative paradigm. Crucial to the understanding of the naturalistic paradigm are five central axioms, a group of 'basic beliefs' set out by Lincoln and Guba (1985 p.33). First among them is the view that realities are multiple and can only be studied holistically in their natural context. Second, the inquirer and the subject of inquiry are interactive and inseparable, therefore influencing each other and the research process. Third, the aim of inquiry is to develop an idiographic body of knowledge in the form of 'working hypotheses' and where only time- and context-bound hypotheses are possible. Fourth, all entities are in a state of 'mutual simultaneous shaping', so that it is impossible to distinguish direct

cause from direct effect when examining the nature of experience. Finally, inquiry (inquirer) is value-bound, influenced by multiple aspects that determine the choice, direction and undertaking of the research (Lincoln and Guba pp.36-38).

Naturalistic Inquiry is used by Lincoln and Guba (1985) to frame qualitative research processes, procedures and techniques that embrace their certain elements. Naturalistic Inquiry, therefore, does not adopt a specific methodological approach from the qualitative research methodological spectrum. It stands on its own as a general approach to research that uses qualitative processes and procedures and, as required at time, may draw on quantitative tools to complement qualitative interrelated holistic understandings of human reality (ies).

Naturalistic Inquiry enables the 'researcher to operate within a social context sharing constructions and building common understandings and directions' (Erlandson et al 1993 p.68). From this process, the final shape of the study and the form in which it will be reported gradually emerge. Allowing for this emerging process is fundamental to naturalistic design (Erlandson et al 1993).

Qualitative research does not focus on establishing cause and effect relationships, rather it allows exploration of a range of human experiences that are of interest to disciplines, such as nursing. The methods used by qualitative researchers enable the gathering of abundant and rich data, which facilitates deep understanding of the human condition. Naturalistic Inquiry facilitates understanding of the complexities of human realities that are constructed and played out in daily living and communication (Erlandson et al 1993).

The use of qualitative research methods is appropriate for determining ‘what people do, know, think, and feel and that some of the effective ways of determining these are by observation and conducting in-depth interviews (Patton 2002 p.145). ‘Qualitative research processes, procedures and techniques are stressed within the naturalistic paradigm not because the paradigm is antiquantitative but because qualitative processes, procedures and techniques come more easily to the human-as-instrument’ (Lincoln and Guba 1985 p.198).

In Naturalistic Inquiry the researcher builds upon his or her own tacit knowledge and uses processes, procedures and techniques such as, interviews, observations, document analysis and unobtrusive clues and the like. Data are composed of ‘quotations, observations, and excerpts from documents’ (Patton 2002 p.47). The researcher investigates a phenomenon as it occurs naturally by observing it in its natural setting or by listening to individuals describes the experiences they have had (Lincoln and Guba 1985). ‘Observations take place in real-world settings and people are interviewed with open-ended questions in places and under conditions that are comfortable for and familiar to them’ (Patton 2002 p.39).

3.2.2 Enable participants to tell ‘their stories’

This study had at its central focus, research into participants’ experiences and perceptions of their partners being admitted into ICU immediately after childbirth. A naturalistic inquiry approach was employed to enable the gathering of rich descriptive data that illuminated the participant’s experiences and perceptions of an area about which previously little was known. The use of Naturalistic Inquiry method enabled the participants to tell ‘their stories’.

Broad research questions in this study:

- What are men's experiences and perceptions of the incidence and impact of their partners being admitted to ICU following the complications of childbirth?
- What is the nature of the relationships and interactions that men had with healthcare professionals before, during and after their partner's ICU admission following the complications of childbirth?
- What impact did the experience of having their partner being admitted to ICU following the complications of childbirth have on the men's relationships with their partner, newborn infant and other children (if any)?
- What impact (if any) did the experiences of having their partner being admitted to ICU following the complications of childbirth have on their future life plans?

The key aims of this study were to:

- Explore men's experiences and perceptions of the incidence and impact of their partners being admitted to ICU following the complications of childbirth;
- Explore and describe the nature of the relationships and interactions that the men had with healthcare professionals before, during and after their partner's ICU admission;
- Discover what impact the experience of their partners being admitted to ICU following complications of childbirth had on men's relationships with their partners, newborn child, and other children;
- Discover what impact (if any) the experiences of their partners being admitted to ICU following complications of childbirth had on their future life plans.

3.2.3 Steps of data collection and data analysis

Naturalistic Inquiry relies on purposive sampling to ensure maximal discovery of problems and the heterogeneous patterns that appear in the context that is under study. The aim of purposive sampling is to identify ‘information-rich cases’ for in-depth examination (Patton 1990 p.169). The purposive sampling procedure is ‘governed by emerging insights about what is relevant to the study and purposively seeks both the typical and the divergent data that these insights suggest’ (Erlandson et al 1993 p.33). Guba (1978) describes Naturalistic Inquiry as ‘a wave’ on which the researcher moves from ‘discovery mode’ to ‘verification mode’ in an attempt to understand the real world.

Sandelowski (1995) suggests that, in qualitative research, determination of an adequate sample size is to ensure that the sample size is neither too small nor too large. That is, that the sample size is not too small to miss gaining new diverse understanding of the phenomenon under investigation, and is not too large to allow case orientated analysis. Sandelowski (2000) purports the aim is to achieve an understanding of the diversity within a small sample rather than try to document narrowly defined aspects of a large sample. Lincoln and Guba (1985) state that sampling should continue until data saturation is achieved, also referred to as ‘the point of redundancy’ (p.202). Sampling is ceased when no new information emerges from new data gathered.

In a naturalistic study, data collection and data analysis are conducted concurrently, it is not a step-by-step process, as there is ‘an inseparable relationship between data collection and data analysis’ (Erlandson et al 1993 p.114). This process was facilitated by following Lincoln and Guba’s (1985) steps of data analysis such as;

‘unitising’, ‘categorising’ and looking for ‘patterns in the data’, to enable themes to emerge during the study (pp.344-350). The interpretation of the study’s findings emerges through the researcher, as a human instrument, familiar with the data and who is able to fine-tune the emerging information ‘in order to generate the most fertile array of data’ (Erlandson et al 1993 p.114).

In summary, the primary challenge of Naturalistic Inquiry studies is to provide descriptions, understanding and explanations of human behaviours and experiences. The researcher sees the underpinnings of Naturalistic Inquiry as strengths in the sense that this approach affords the best opportunity for gathering rich and holistic data about the experience of men whose partners have been admitted to ICU immediately after childbirth.

3.3 Method

The most common qualitative methods employed in nursing research are phenomenology, grounded theory, ethnography, critical social theory, action research, historical research, heuristics and philosophic inquiry. Naturalistic Inquiry research was chosen for this study since it was the method most amenable to achieving the aims and purposes of the study.

In keeping with the tenets of a systematic inquiry, this study was advanced using the following steps:

- Sample selection and access;
- Data collection;
- Interviews;
- Data analysis;

- Data presentation and dissemination of research findings.

Each of these processes is described below, under separate subheadings.

3.3.1 Sample selection

In the following discussion, consideration is given to describing the sample type and the size, the processes employed for recruiting and accessing the participants, and the demographics of the participants recruited.

A purposive sample of sixteen (16) men was invited to participate in the study. The participants were selected on the basis of the following criteria:

- their partner was admitted to ICU immediately after childbirth;
- they spoke English; and
- their partner had given birth within the last 2 years.

At the commencement of the study there were no limits set on the number of participants to be interviewed. The number of participants recruited to the study was determined by informational redundancy. Informational redundancy is determined once ‘nothing new’ emerges from the interviews. After the 16th interview it was apparent that informational redundancy had been achieved and sampling was stopped.

Participant profile

The data were obtained from analysing 16 interviews conducted with 16 participants. Participants whose partners had been admitted to an ICU immediately after childbirth were interviewed.

The participants were:

- All male;
- All biological fathers of the newborn infants
- All married at the time of interview;
- Ranged between 23 – 46 years of age.

Of these participants:

- Three had children from previous relationships;
- 13 were in full time work;
- 1 a full-time carer for his partner and baby;
- 1 was a full time student;
- 1 was on sick leave.

The participants' partners gave birth to live infants in one of six maternity hospitals located within metropolitan Melbourne. Nine women were transferred to an ICU within the hospital where they gave birth and seven women were transferred to another ICU in a different hospital. Of these nine women, all were separated from their newborn infants, as eight of the infants remained in the maternity hospital and one infant required the technological support of a NICU of a specialised hospital (Table 4.1).

Partner	Women transferred to ICU in maternity hospital	Women transferred to ICU in different hospital	Newborn infant stayed in maternity hospital	Newborn infant transferred to NICU different hospital
P 1		X	X	
P 2	X		X	
P 3	X		X	
P 4	X		X	
P 5		X	X	
P 6		X		X
P 7		X	X	
P 8	X		X	
P 9	X			X
P 10	X		X	
P 11	X		X	
P 12	X		X	
P 13		X	X	
P 14	X		X	
P 15		X	X	
P 16		X	X	

Table 4.1 Birthing Outcomes

Three of the men had children (total n=6) from previous relationships. Of their partners 8 were primigravida⁹ and 8 were multigravida¹⁰. Of these women 3 remained intubated¹¹ while in ICU, one was on ECMO¹², 4 had hysterectomies and one had a detached retina. All pregnancies were singletons. Two newborns were premature¹³, 29 weeks gestation and 22 weeks gestation. The 22-week gestation newborn infant died of complications five weeks after birth. Three newborns were admitted to Neonatal Intensive Care (NICU). Two of these newborn infants were transferred to NICU in another large teaching hospital. In all other cases the newborns remained in the maternity hospital until the mother was transferred back. In each of these cases the

⁹ A woman pregnant for the first time

¹⁰ A woman who is pregnant for the second or subsequent time

¹¹ The process of putting a tube down someone's throat into the trachea; the tube is connected to a ventilator that delivers measured amounts of oxygen into the lungs (and then lets it out again) to help the person breathe.

¹² Extracorporeal membrane oxygenation is used when a patient has a condition which prevents the lungs from working properly. An operation is performed to insert tubes (cannulae) into a large vein, which carries the blood to the ECMO circuit to oxygenate the blood, and back again to a large vein or artery. The ECMO circuit provides a temporary lung and allows the patient's lungs to rest and recover. The patient remains on a ventilator but all the settings will be lower than before, to minimise damage to the lungs.

¹³ One born before 37 completed weeks gestation i.e. 259 days

woman's obstetrician did not visit her in the large metropolitan hospital. The men's partners were in ICU for an average of 2.2 days (total n=35 days). Seven of these women were transferred from the maternity hospital to a larger metropolitan hospital ICU, an average of 2.15 days (total n=15 days) spent in separate hospitals.

Complication	Number of women	Average number of days in ICU
PPH	12	12
HELLP syndrome	1	4
Seizures	2	2
Amniotic Fluid Embolism	1	5
Total	16	23

Table 4.2 Post delivery complications

3.3.1.1 Sample recruitment and access

To access participants for this study a variety of methods were employed. This was necessary as the process of recruitment as some methods proved to be more successful than others. The use of various methods overcame recruitment difficulties, even though quite a lot of time was spent in this process.

The various recruitment methods employed to access the sixteen (16) men in this study are presented below:

Access via a local newspaper article

An article describing the study was published in the local newspaper (Appendix 1). A reporter from the local newspaper interviewed the researcher and an article, detailing the study and inviting male participants to partake in the study, was printed. This article reported personal comments of the researcher, which described the purpose of

the study and the request for volunteers. Two participants were recruited via this method.

Access via an RMIT University media release

After being contacted by the researcher, the RMIT University Publicist sent a media release email to RMIT personnel (Appendix 2). It contained a brief description of the study and asked for volunteers. Only one participant was recruited through this media release.

Access via direct mailing

The most successful method of recruitment was sending out a letter, with a brief outline of the study, to past intensive care patients (Appendix 3). After permission was obtained from the RMIT University Human Research Ethics Committee (HREC) (Appendix 8) and the HREC of two hospitals, a letter, outlining the purpose of the study, was sent from an intensive care Data Manager to former intensive care patients' inviting their partner's to participate. The letter included the ICUs secretary's details stating if they were not interested in participating in the study to contact the secretary and no further contact would be made. However, if after two weeks no contact had been made with the ICUs secretary the past patient's phone number would be passed on to the researcher to make contact seeking permission to interview her partner. This yielded 11 participants and was by far the most successful way of recruitment.

Access via snowball sampling

Two participants were recruited using snowball sampling, a method whereby a participant already in the study invites another person to participate in the study (Morse 1991 p.130). Two participants of the study told friends about the researcher's

study. The participants involved in the study contacted the researcher in regards to their friends who had had similar experiences and were keen to partake in the study. The men contacted the researcher who gave them information regarding the study and answered their questions. Two participants were recruited via word of mouth.

Maternal and Child Health Nurses Regional Meeting

The researcher also presented the research topic to 300 Maternal and Child Health Nurses at a regional meeting. At this meeting the researcher displayed an overhead copy of the recruitment letter and personal contact details. Recruitment letters were placed on notice boards within some of the Maternal and Child Health Centres (Appendix 4). This was unsuccessful in recruiting any participants for the study.

3.3.1.2 Sample description

The purposive sampling technique was used to select participants for the study. To get access to ‘rich data’ participants were selected purposefully and led to learning ‘a great deal about issues of central importance to the purpose of the research’ (Patton 2002 p.46). The purposive sampling technique involved selecting participants who had experienced and were knowledgeable about the topic, and were willing and able to share their insights about the phenomenon being studied (Erlandson et al 1993 p.148).

The research sample consisted of sixteen (16) male participants who had experienced the phenomenon under investigation in this study. Their ages ranged from 23-46 years old.

3.3.2 Data collection

Data were collected via semi-structured conversational interviews using open-ended questions. The interviews were conducted at times of the day that were mutually agreeable, commencing between 10 a.m. to 9 p.m. All interviews were audiotaped and the duration of the interviews ranged from 45 minutes to 120 minutes, with the initial interviews lasting the longest. The interviews were conducted over an 18 month period. This time span was primarily determined due to the difficulty in accessing participants.

Simultaneous data collection and analysis enabled the researcher to develop and reshape questions that facilitated in subsequent interviews a deeper and more holistic exploration of the phenomenon under study.

Initial contact was made with the potential participant over the phone. In most instances the researcher had already had a lengthy discussion with the participant's partner prior to speaking to the participants. In most instances the men's partners were keen for the men to participate in the study, stating 'it would be good for him' or 'hasn't really discussed it with anyone.' The participant's partner would either pass the message on for their partners to contact the researcher or the participant's partner would ask the researcher to call back at a specified time. The researcher spent some time while on the phone informing the men about the study and answering any questions they had. Some of the men reiterated what their partners had said, such as 'I haven't discussed this with anyone' and some thought they might not be of any benefit in they study, 'don't know if I can be of much help.' The researcher was mindful that talking about his experience could be upsetting and displayed 'empathetic neutrality' by allowing the potential participant to discuss whatever

concerns he may have and answering the questions truthfully and without judgement (Patton 2002).

Open-ended questions that were used to guide each interview of this thesis are included in Appendix 7.

Upon meeting the participants for the first time, initial introductions and appropriate greetings were made, and then the conversation would turn to small talk about the neighbourhood or drive to the meeting place. Pleasantries were exchanged, offers of a beverage or biscuit prior to commencing the interview, which in most cases was declined. The conversation changed to the topic of the study once the researcher and participant were seated in a room and alone. To build rapport with each of the participants the researcher would ask general questions about his family. The researcher gave the participants a background to why she was conducting the research and some information about herself, which received a favourable response from each of the participants. The researcher, who is a midwife and a critical care nurse, was working in a busy ICU in a metropolitan hospital and who on occasion, because of her midwifery experience, was required to look after women who had just given birth. All of these women had been transferred from a hospital where they had given birth and their newborn infants remained there. Upon visiting their partner in ICU, the men were understandably distressed at seeing their partner. The researcher explained to the participants that she was interested in gaining more insight into the men's experiences, and questioned if there was anything more they believed could have done when looking after these women. This gave the men time to think and ask her as a researcher any questions they might have about the research.

The researcher would then explain to each participant the aim and purpose of the research study, the techniques of data collection and how the data would be used. All participants agreed to the researcher taking notes and the use of an audiotape to record the interviews. The researcher outlined how confidentiality and anonymity would be upheld during the study. For example, assurance was given that no identifying names would be disclosed in the study. Participant's questions and queries were answered prior to commencing the interviews. At this point, verbal and written consent was obtained, with the researcher informing them that the study was entirely voluntary and they could withdraw from the study at any time. The researcher asked for permission to use an audiotape and to make notes during the interview, which all participants agreed to.

Interviews held in the library or offices were uninterrupted and privacy was provided. Interviews held at the participant's house were sometimes disrupted with participants' partners, and at times, their children coming in to the room where the interview was taking place. In most cases this was towards the end of the interview, and often initiated by the participant calling out to his partner to clarify a name of an obstetrician, doctor or nurse or the time of a particular event.

In most cases a question was asked earlier in the interview and the participant couldn't recall a name, time or place and toward the end of the interview they would say things like, 'this is bugging me...I have to ask (partner's name) or 'I just don't remember his (doctor's) name (calls out partner's name)...what was the name of that eye doctor?' In all cases their partners were able to give them the correct information according to the participants.

An interview guide was developed using a list of basic questions and issues to be explored, but neither using fixed words or ordering of questions is predetermined (Minichiello et al 1995). The research questions were phrased in a way to enable the researcher to develop and explore theory that emerged from the context being studied. During these interviews participants were asked to ‘Tell me about your experiences and perceptions of the impact of your partner being admitted to ICU immediately after childbirth?’ All of the participants began their stories from the obstetric crises that occurred prior to their partner’s admission to ICU. For example, *‘Yeah, it was all a bit sudden. My daughter was 11 weeks prem and (partner’s name) had placenta praevia and then what happened was, well a brief background...’ (P1)*. Questions were rephrased during the interview process for the purpose of giving the participants the opportunity to explore, verify and express hidden meanings. Further questions to these answers were followed up with more probing open-ended questions to seek clarification regarding their responses. For example, if they gave an array of words describing a particular experience, this was followed up with, ‘tell me why it made you feel that way,’ ‘how did you deal with it,’ and ‘tell me why you did that?’ During the interviews the researcher was mindful to remain engaged, and not to look detached or uninterested in what the participant had to say. The researcher would nod in acknowledgment or use facial expressions to convey empathy and understanding back to the participant. The researcher would try to convey to the participant that from his description of events she understood exactly what he went through.

The interview from the first participant was transcribed verbatim and analysed prior to proceeding to the next interview. These transcriptions were read several times. As the study progressed, the interviews became guided by the emerging patterns and

themes. Themes that emerged from each interview guided the direction of the next interview, and the formulation of additional relevant research questions required for deeper more holistic exploration of the phenomenon. During each of the interviews field notes were taken. This was difficult to do as when writing while the participant spoke the researcher felt that not enough attention was being given to what was being said, and that valuable information would be lost. The researcher then jotted down key concepts and asked them to expand on them at the end of the interview. Such concepts were for example as, 'torn between the two', 'aloneness' 'lack of direction' 'too much information' and 'juggling and not doing anything right.'

The researcher also kept a reflexive journal and would jot down observations, feelings and thoughts while observing participant's body language, behaviour and interactions while interviewing in the social situation. Notes were made in the journal during each interview. The journal also contained a record of my entries, which ranged from ideas, problems, frustrations and sometimes breakthroughs. A comment noted in the journal that when the participant answered the door to his house the researcher noted that he had bare feet and that there was a row of shoes at the entrance, the researcher, 'took shoes off-glad I made sure had socks on with no holes.' There was a pattern noted in the journal that, initially, participants were a little nervous and would 'apologise' for this but after 5-10 minutes the participants relaxed. The participants explained to the researcher that they felt the nervousness was because they had not spoken to anyone about their experience. The researcher noted in the reflexive journal that after listening to the first interview that she was 'butting in', often it was to clarify a concept, while the participant was still answering a question. The researcher made a note to 'jot down a word to remind you of the question' thereby allowing the participant to finish the question so line of thought not disrupted and then ask for

clarification and more detail. The reflexive journal also recorded some lowlights and highlights experienced during the research process. One difficulty experienced was the researcher's difficulty in accessing 'key-informants.'

The researcher presented her research topic at a Maternal and Child Health Nurses Regional meeting and gave out recruitment letters, distributed recruitment letters on hospital and Maternal and Child Health Centre notice boards, had an article published in the local newspaper and a media release sent to RMIT personnel and these strategies only attracted 3 participants. The researcher wrote in her journal that she was 'Going about this the wrong way' in attracting potential participants to her study. There was a positive entry after the researcher revised how best to access 'key-informants' by sending out letters to past ICU patients of two hospitals inviting their partners to participate in the study. This was the entry in her journal, 'Finally...success...have phoned first potential participant and arranged meeting for an interview.'

The interviews were audiotape-recorded and the tapes given to a professional transcribers for transcription. A master copy of each transcript was saved on disks together with a "clean" hard copy. Further copies were made of each transcript for analysis. After each interview the researcher listened to the tapes prior to having them transcribed. This enabled notes to be jotted down and helped the researcher to become closer to the data and to detect emerging patterns and themes. This enabled the researcher to gather deeper and rich data and to check the prevalence and meanings of such patterns in subsequent interviews. When taped interviews were transcribed, the researcher would listen to the tape while the transcript was read. This was done to check for transcription errors, to note the tone of the participant's voice, pauses and

various other enunciations. In some instances the typist was unable to distinguish a word, due to laughter or both researcher and participant speaking at once. In most cases because the researcher had undertaken all interviews and had listened to the tape the word was often recalled.

3.3.3 Data analysis

In keeping with the tenets of Naturalistic Inquiry, data were analysed using content and thematic analysis strategies. According to Lincoln and Guba, Naturalistic Inquiry employs inductive data analysis that ‘aims at uncovering embedded information and making it explicit’ (1985, p.203). This approach of analysis is deemed more likely to capture the essences of individual realities found in the data.

As already stated, the processes of data collection and analysis were concurrent and intertwined. Data analysis was not delayed until data collection was completed; rather collection and analysis of data gathered occur simultaneously as patterns and themes emerged during the study.

Inductive analysis was employed to sort the data into themes that encapsulated descriptive participant’s descriptive information about the context from which the themes were deduced. Specific units of information were sorted and set into provisional themes on the basis of similar characteristics. Units were sorted, if its content had the same feel as an existing theme the unit was added to it. If it didn’t ‘fit’ into the existing themes the unit was set aside as the first entry in a new theme. Some themes that emerged were named using the participant’s own words. If, however, the unit could not be supported by the emerging themes it was placed in a miscellaneous pile. Some of the themes changed and some disappeared or were merged with other themes. This process continued until all of the units had been assigned to themes, that

is, all units were exhausted. The next step was to focus on and review the themes that had emerged and the process that had been followed was repeated. This process was no less emergent than the first. This process was important as it enabled the researcher not to limit herself to the original themes but enabled new themes to emerge. Themes that had emerged were compared for patterns, linkages, plausible explanations, similarities and differences. Some themes merged and some original themes disappeared. This process ceased when there were no new themes. At all times, during this process, notes were written down, annotations were made in the margins of the transcripts and the data were scrutinised for patterns and linkages across the categories. Memos also included diagrams to help the researcher better visualise the emerging concepts. Memos, documents, field notes and non-verbal cues, which described the researcher's thoughts about the relationship between the data, were written in a separate book with links to the original data recorded for each.

Data were analysed using the three phases of Naturalistic Inquiry. The first phase was to 'get some handle on what is salient (that is, what one needs to find out about),' then the second phase was used to 'find out about it' and the third phase was used to 'to check the findings in accordance with trustworthiness procedures and gaining closure' (Lincoln and Guba 1985 p.235). As data analysis progressed there was significant overlapping of these phases.

3.3.4 Presentation and dissemination of research findings

The findings of this research inquiry are presented in this report. The researcher has presented the preliminary findings of her research study before audiences at two health, nursing-midwifery forums. It is the researcher's intention to disseminate the findings by submitting articles for publication in professional peer-reviewed journals.

3.4 Research rigour and validity

In keeping with the framework of Naturalistic Inquiry, due consideration was given to upholding research rigour via maintaining the commonly accepted principles of: credibility, fittingness, auditability, confirmability and triangulation (Lincoln and Guba 1985; Sandelowski 1986; Patton 2002). Within these principles were specific methodological strategies for demonstrating qualitative rigour such as, audit trail; member checks when coding, categorising, or confirming results with participants; peer debriefing; negative case analysis; structural corroboration; and referential material adequacy (Lincoln and Guba 1985).

Lincoln and Guba (1985) advised researchers to employ a variety of measures to ensure trustworthiness of the data gathering and analysis phases during Naturalistic Inquiry. Steps to ensure trustworthiness and creditability are necessary to ensure the authenticity of the storied interpretations and the findings and enhance the ability to transfer interpretations to the settings and situations. Sandolowski (1986) states that ‘truth is subject-orientated rather than researcher-defined’ and that participant verification is the most effective way of ensuring validity of a qualitative study (p.30). Valid inquiry must demonstrate its truth-value, providing the basis for applying it, and enable ‘external judgements to be made about the consistency of its procedures and the neutrality of its findings or decisions (Erlandson 1993 p.29). Lincoln and Guba (1985) refer to these characteristics as ‘trustworthiness.’

3.4.1 Credibility

Credibility is the criterion in which truth-value is evaluated in qualitative research (Lincoln and Guba 1985; Erlandson et al 1993). It is demonstrated when participants, and others who have had a similar experience, recognize the researcher’s described

experiences as their own (Beck 1993). When the description generated through inquiry in a certain setting ‘rings true’ for those individuals who are members of that setting credibility is established (Lincoln and Guba 1985 p.30). According to Lincoln and Guba (1985) credibility is established through prolonged participation with participants. Credibility relates to the trustworthiness of the findings in the study.

Credibility refers to providing interpretations of the participants’ experiences in a way that is perceived as ‘one’s own’ by those with similar experiences (Sandelowski 1986). To ensure the credibility of this study, the researcher endeavoured to reflect the views of the participants faithfully when assigning themes. The information the researcher collected from the participants was of high quality perceptual data. Audiotaping the interviews, collecting field notes, maintaining a reflexive journal and using direct quotes within the data presentation achieved this.

Member checking provides for credibility by enabling the individual participants included in the study verify data and interpretations collected via the study. Member checking can be conducted towards the end of an interview by summarising the data and enabling the participant to verify or challenge the researcher’s interpretations (Lincoln and Guba 1985 p.142). Member checking can be conducted by verifying with participants’ interpretations collected in previous interviews. In this study, member checking was conducted at the end of each interview by summarising data and allowing the participant to confirm or deny the researcher interpretations. Also member checking was also conducted in interviews by verifying interpretations collected in previous interviews.

Time spent with participants, interviewing them and spent observing them at their research site is seen as building trust. In this study the researcher's time was limited to phone calls prior to the interview and then the interview itself. Participant observation was limited to the interview and site it was conducted at. The time spent with the participant was usually no longer than 2.5 hours. Glesne (1999) advocates long term observation, that participants are 'less readily to feign behaviour' and 'are more readily to be frank and comprehensive about what they tell you' (p.151).

Although Lincoln and Guba (1985) advise not to over identify with the participant or start to lose research perspective by 'going native' (p.304). Prolonged persistent observation can run the risk that the researcher may lose the 'detached wonder' and risk failing to uncover certain phenomena that the 'relatively uninvolved researcher would discover' (Lincoln and Guba 2002 p.304).

3.4.2 Auditability

Auditability was maintained by leaving a clear decision trail, concerning the study, which can be followed, from beginning to end, by another researcher to confirm how decisions were made and how certain paths were taken (Sandelowski 1986). Sandelowski (1986) states that a 'study and its findings are auditable when another researcher can clearly follow the 'decision trail' used by the investigator in the study' (p.33) During this study an 'audit trail' was kept, by describing the study, why it was done, how it was achieved within this chapter and other chapters of the research report. The participants' quotes were utilised 'verbatim' within the data presentation. The original audiotapes, transcripts of the interviews and field notes have been retained, and can be checked for the purposes of confirming accuracy of the data present in the final report. Thus enabling any person wanting to replicate the study

should arrive at similar, but not contradictory findings (Sandelowski 1986). This audit trail served as a checking system for the researcher and a system to recheck the validity of data collected.

3.4.3 Fittingness

The criterion of fittingness, also known as transferability, looks at applicability of a study's findings outside the setting of the study. Fittingness is said to be achieved when the audience views the study findings as 'meaningful and applicable' in terms of the audience's own experiences (Sandelowski 1986). In this study, the findings, supported with the use of thick description of data, deemed applicable and meaningful if they 'fit' with the reader's experience in a different context (Lincoln and Guba 1985). To achieve this, the researcher constantly referred back to the transcriptions when developing and confirming themes.

The research has also presented the findings in two health, nursing-midwifery forums and received substantial comments in regard to the findings. Validity of the findings has been confirmed through the researcher presenting preliminary research findings of her research to audiences who attended the health, nursing-midwifery forums. Feedback from these audiences has indicated a strong degree of transferability or 'fit' as they, the audiences, found the research findings to be meaningful and applicable in terms of their own experiences, and/or as being intensely applicable to the organisations and contexts in which they are currently employed.

The Naturalistic Inquiry must also meet the criterion of consistency. If this inquiry were repeated using the same individuals in the same context its findings would be

the same. Consistency is understood in terms of dependability. Dependability encompasses reliability, a precondition for validity, and traceability required by explainable changes (Lincoln and Guba 1985).

Finally, the inquiry is 'tested' for its degree to which its results are central to the inquiry and not the 'biases of the researcher.' 'This means that data constructions, assertions, facts, and so on can be tracked to their sources, and that the logic used to assemble the interpretations into structurally coherent and corroborating wholes is both explicit and implicit' (Lincoln and Guba 1989 p.243).

3.5 Limitations of the study

The researcher is a midwife, of 23 years, and intensive care nurse, with 19 years of experience working in ICUs. The researcher's insight as a nurse was an added strength that enabled an empathetic involvement in the collection of data via in-depth interviewing. Empathy encompasses being able to understand feelings and experiences from another person's viewpoint. Thus, with the researcher's professional background as a nurse, it could be seen to contribute to the understanding of the men's perceptions and experiences.

A strength of this study exists in the attributes of qualitative explorative research methodology, which contributed to diverse and rich data collection. In conducting face-to-face interviews with the participants enabled rich data to be collected as the researcher was able to ask pertinent, meaningful and contextual questions to capture 'life as experienced by participants' and to explore ambiguities and participant interpretations (Patton 2002). To remain detached could have limited the researcher's understanding and openness to the phenomenon being studied. Remaining detached does not necessarily guarantee objectivity. Recognising that objectivity is unattainable

when researching human experiences, thoughts, perceptions and interpretations as well as social interactions, is to recognise the existence of multiple human realities and the need to follow rigorous research processes and procedures to capture such realities.

Patton (2002) suggests the qualitative researcher be in close contact with their participants 'rigorously observing and interviewing to understand the people and situation being studied,' and in doing so, adopt a stance of 'empathetic neutrality' (p.51). The researcher employed 'empathetic neutrality' during the course of interviewing, and employed established techniques of efficient interviewing, that is, the use of carefully worded open-ended questions, engaging in a conversational style of interview, not to impose personal points of view on participants, all interviews were audiotaped and transcribed verbatim and the provision of truthful representation of the participants views. The researcher must be aware not to become too involved as this could cloud judgement, but to be too distant could reduce understanding in regard to the phenomenon being studied (Patton 2002 p.50). During the study the researcher adopted a stance of 'empathetic neutrality'. The researcher went into the study with no predetermined theory or results to prove. The researcher was committed to seeking a study that was honest, meaningful and credible.

The researcher's own interpretations and assumptions as they emerged during the interviews and analysis were addressed at the time of the interviews and at other subsequent interviews. This was done by sharing these with the participant in the form of questions which when answered revealed agreement or disagreement that existed between researcher and participant.

Naturalistic Inquiry can be informative and provide a baseline for further studies. This study could establish a basis for further research, which can be used to inform policy and procedure development relative to the population being studied.

This study is not without its limitations. This qualitative research study was the first study undertaken by the researcher. Therefore, limitations arose as a result of the researcher being a novice researcher. Analysis of the data identified that some of the questions may not have been probing enough and this may have resulted in data not being captured.

The sample size of 16 participants is small due to the nature of the sample and data collection the information gained from this qualitative study could not be generalised to the general population. The men in this study were selected purposively and therefore this group of men may not be representative of other men in the population. The aim of this study was not to generalise but to improve understanding and gain insight of the human experience, which can also open up scope for further research in this area.

Recruitment to participate in the study was open to all people. No same sex couples or people in de-facto relationships sought to be involved in the study, only married men sought to participate.

It is acknowledged by the researcher that triangulation strengthens the study by combining methods, but once again due to time and resource restraints triangulation was not done.

In summary, a qualitative explorative research methodology provided a framework to explore and gain understanding of men's experiences and perceptions of what it was like for them when their partners were admitted to ICU immediately after childbirth.

3.6 Ethics approval process

3.6.1 Informed consent

Prior to each interview the participants were given a plain language statement (Appendix 5) and consent form (see Appendix 6), which explained the purpose of the study and steps taken, to maintain confidentiality and anonymity. All of the participants in this study gave their consent to participate and signed the consent form. Prior each interview the participants were given the opportunity to ask questions about the study. Participants were also advised that participation in the study was voluntary, and if at any time they wished to leave the study they could.

3.6.2 Confidentiality

Data security was assured by allowing only the researcher and the researcher's supervisors' access to the interview transcripts. In accordance with the HREC policies all data pertaining to the study are stored securely. All data will be stored for a further 5 years after completion of the study. After this time all data pertaining to the study will be destroyed according to RMIT University and National Health and Medical Research Council (NHMRC) guidelines.

3.6.3 Anonymity

Throughout the study anonymity of the participants was assured and maintained via the use of codes so that no name or identifying information remained with the data or were utilised in the study. The codebook contained the code number of the

participant, the name and demographics of the participant. This book was kept in a secure place and was only accessible to the researcher. The interviews were typed by a professional typist who was aware of the importance of maintaining anonymity of the participants, and who agreed to maintain confidentiality. Participants' names were not typed in the transcription, instead the letter 'P' typed in the left hand margin to identify the participant and the letter was used 'R' to identify the researcher.

Before joining the study, participants were also informed that the results of the study might appear in publications. This information was divulged to the participants prior to obtaining informed consent. Participants were informed that if any presentations at seminars or publications were to arise out of the findings confidentiality and anonymity would be assured, as no identifying names or names of places would be used.

3.6.4 Level of risk

Prior to commencement of the study permission was obtained from the RMIT University HREC and the HREC of two hospitals. In assessing the balance of benefits and harms of the participants participating in the study the proposal was submitted as a minimal risk (MR) study.

The researcher was aware of the possibility that some participants might experience some distress when recalling certain experiences while his partner was in an ICU. This would be partly due to the participants contributing information that they might not have shared in other circumstances. During each interview the researcher was ready to cease the interview and discuss concerns if the participant became distressed. While the researcher is a nurse, and experienced in giving emotional support, a list of

appropriate health support services was readily available in case they were needed. The researcher did ask four participants if they were in discomfort during the interview and whether they would prefer the interview to cease. In each instance the researcher asked the participant if he wished to withdraw from the study. Each of the participants wished to continue with the interview, stating that this was the first time they had spoken at length about this experience. At the end of each interview the researcher asked if the participants would like to discuss any concerns they might have. All the men gave full consent for inclusion of their interviews in the study.

3.7 CONCLUSION

This chapter has provided rationale and information regarding the methodology used for this study. The Naturalistic Inquiry research approach chosen for this study described the process for sampling, data collection and analysis, presentation and dissemination of the research findings and the steps used to ensure research rigour and credibility of the research findings. Finally, limitations of the study and the processes undertaken to ensure compliance with the research ethical considerations have been explained.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 INTRODUCTION

In this chapter, attention is given to presenting the data collected during the course of undertaking the study. The analysis of the data reveals the perceptions and experiences that partners of the birthing women had in regard to their preparations for, and expectations of, a normal birth. The analysis of data obtained from 16 individual semi-structured interviews of participants knowledge, understandings, descriptions, perceptions and experiences of the:

- Incidence and impact of their partners being admitted into an ICU following the complications of childbirth;
- Nature of the relationships and interactions that men have with healthcare professionals before, during and after their partners being admitted to ICU following the complications of childbirth;
- Impact of the experience of their partners being admitted to ICU following the complications of childbirth had on the men's relationships with their partner, newborn child, and other children;
- Impact of their partners being admitted to ICU following the complications of childbirth had on their future life plans.

4.1.1 Findings

Overall data strongly suggested that while the men were preparing for a happy and joyful event they were overwhelmingly, suddenly and unexpectedly confronted with their partner's life-threatening event that took them through an unknown traumatic

and enlightening journey. In this journey the men found themselves to be alone and struggling to make sense of the critical health events and care their partners were receiving. They found themselves witnessing and experiencing a situation with little understanding or support from health professionals within a modern technologically and educationally advanced healthcare system. The men's journeys are described below, under the following six subheadings:

1. Men's experiences and perceptions of their partner's admission to ICU;
2. Relationships and interactions with healthcare professionals;
3. Impact on men and their family during their partner's ICU's admission;
4. Men's fears and anxieties during the crises and their legacy;
5. Impact on men and their future life plans;
6. Conclusion.

4.2 Men's experiences and perceptions of their partners' admission to ICU

Despite feeling prepared and well-informed about childbirth, many of the men felt totally out of control and forced to succumb to medical control when their partner's experienced complications immediately after childbirth.

4.2.1 Men's expectations of their partners' birthing

All of the men expected their partners to have uncomplicated births, even the two men whose partners had been inpatients for ten and twelve weeks prior to the birth of their newborn infants. Most of the men interviewed stated that their partners were well during their pregnancies. The men that had attended antenatal classes, run by midwives, stated that there was no information given during the antenatal classes pertaining to complications after childbirth. Men expressed that during the antenatal

class the healthcare professionals did not state that some women may experience severe complications:

‘But nobody prepares you, nobody even say in antenatal class that there is a 1% chance that this could happen, not that they are going to do that’ (P8:14).

One man had thought there could be some dangers associated with childbirth, however his faith in the Australian health system sustained his belief that ‘a normal birth will take place:

‘...of course you go in with a positive attitude and you think, yeah ok, look there’s dangers but we’re in good hands and we’re informed...it’s the old denial type thing, you just think “oh yeah, it’s not going to happen to us’ (P3:1).

Although, many men attend antenatal classes, it is not clear if this prepares them for the birthing process or for any adverse complications. In the context of this study, one man explained how he did not feel at all prepared for his partner’s labour, delivery of their infant or of the complications that followed. He found the experience extremely traumatic, he was unsure of his role and felt he could not empathise with his partner:

‘...because traditionally a man has never been part of the giving birth, men didn’t traditionally sit in the delivery room, they really didn’t have much to do with it, and now you’re expected to be part of that...male, whatever you call it, role...so ok, I’m there with my wife but it’s extremely traumatic for a man to be there...a male doesn’t know what’s going on, you can’t do anything when someone you love is over there having a baby, which is quite natural...you are wondering “what does it feel like to have this baby with a head that big popping out”...you wonder does your joy overwhelm your pain...but you want to be there for your wife’ (P8:16).

Another man’s partner was diagnosed with placenta praevia¹⁴ and was admitted to an antenatal ward twelve weeks before the birth of their infant. When she experienced complications after the birth, due to an amniotic embolism, her partner explained that

¹⁴ Also known as low lying placenta is a complication of pregnancy, where the placenta is in the lower segment of the uterus and covers part of or the entire cervix.

‘no-one’, no healthcare professional, had discussed the risks that could occur after childbirth:

‘...we didn’t expect it...when they (healthcare professionals) told me what went wrong, I thought, I had no idea of this, an amniotic embolism’ (P7:11).

This was not a uniform experience, however. Some men in this study felt that the information they received was adequate. For example, one man and his partner were given information regarding the planned caesarean section:

‘Yeah, fully informed and they said, look, if all goes well there will be an epidural and it will be a normal caesarean birth anyway, and that will be fine you will be able to be here...if things don’t go to plan you will need to leave immediately. They (healthcare professionals) made it very clear and I said, “fine”’ (P3:1).

4.2.2 Experiencing and witnessing a partner’s crisis

The impact of the crisis, leading to the admission of a partner to ICU immediately after complications of childbirth, was sudden and catastrophic for the men. The obstetric crises occurred either in the birthing suite, theatre or the mens’ partners’ rooms in the hospital. Fourteen of the men in this study were present at the time of their partner’s crisis. Two of the men who did not witness their partner’s health crises were contacted, by a midwife, at home by phone and asked to come into the hospital. Several of the mens’ partners were booked for planned caesarean sections, and the men were in attendance with them. Prior to entering the theatre the men were given brief information of what to do while in theatre. The healthcare professionals also informed the men that if there were complications, such as excessive bleeding, they would be asked to leave. One man attended his partner’s planned caesarean section. He was informed by the theatre nurse that he must ‘wear the red hat, do not take it off, this shows you’re the father’ (P4:19). When his partner experienced complications he

was taken out of the theatre, by the theatre nurse, and was left waiting with no explanation.

For some of the men their partners' obstetric crisis occurred a few hours after childbirth. For those men who witnessed their partner's collapse it was a sudden and frightening experience, given, at the time they were in the situation where they were involved in their partner's physical emergency and were the ones at the forefront summoning help from healthcare professionals. For example, one man's partner had given birth a few hours earlier and they had just said goodbye to family. He walked the visitors downstairs and on returning to the room his partner quickly passed their newborn infant to him. She immediately lost consciousness and he witnessed her have a seizure. He panicked and started calling for the midwives and doctors to come and help his partner who was unresponsive:

'...her eyes were twitching, her muscles, her hands seemed to have clammed up, I felt like I was losing her. I was calling her name, just to stay with me type of thing...I can't recall exactly what happened, I think they (nurses) took her away and asked me to stay there. Up until that moment I remember vividly but after the seizure I can't be specific about what exactly took place and whether I went with her or whether I stayed behind with the baby. I am not sure. I think I stayed behind and I went over there (ICU) a little bit later' (P16:2).

4.2.2.1 Men not present during partner's obstetric crisis

Two of the men did not witness their partner's obstetric crisis immediately after childbirth but were phoned at home and informed by the midwife. The midwife asked the men to come into the hospital immediately. Often as little information, such as, 'your wife's bleeding' or 'come in now' was all that was given to them, and so the men often thought the worst. As they drove into the hospital they had feelings of trepidation for the future of their partner, newborn infant and other children.

4.2.2.2 Not enough information

When speaking by phone the midwives gave the men very little information as to why their partner needed to go to theatre. The men who ‘didn’t have enough information’ on the condition of their partner or newborn infant felt out of control and ‘helpless’. One of the men who had witnessed his partners collapse after childbirth earlier that day was encouraged by the midwives to go home. He was ‘hesitant’, as he had planned to stay with his partner and newborn infant overnight. He went home and then received a phone call from a midwife telling him that his partner was going to theatre. He received no further information other than he needed to come back to the hospital:

‘I was really hesitant about it...I really didn’t want to leave both (newborn infant’s name deleted) and (partner’s name deleted) but look at the end of the day this is a hospital and if I’m going to be in the way and they (midwives) don’t think it’s going to be a good idea then I need to take their professional opinion and do what they ask...but later that night I get a call...”going to take your wife to theatre”...so I took off like a bat out of hell...I just didn’t have enough information...don’t know what is going on and feel helpless...no explanation and no mention of the baby’ (P11:5).

4.2.2.3 Couldn’t do anything properly

At the time of crisis or when their partner’s were in ICU the participants were making all of the decisions on behalf of them. Some of the men still question themselves regarding the decisions they made while their partner was in ICU. For example, did they make the right decision at that time? Juggling, visiting the baby, visiting their partner, organising childcare for other children, going to work, contacting other family members, go home to rest: *‘I couldn’t do anything properly’ (P3:20).*

4.2.3 Men's partners admitted to theatre

While their partner was in the operating theatre the men, given no guidance or direction from the healthcare professionals, were unsure of what to do or where to go. Men were trying to find ways to cope with the situations they found themselves in. It was very difficult however, and caused them significant anguish of what to do as they operated in a deserted and information deficient environment.

4.2.3.1 Not much choice

At the time of the crisis, when the mens' partners were taken to theatre, they were asked to sign a consent form on the partner's behalf. Due to the emergency of the situation, information given to the men by the medical staff for consent purposes was brief. These signed consent forms were often for consent for the medical staff to perform hysterectomies if the bleeding from the uterus could not be stopped by any other surgical means. So the men, left alone waiting, were not sure if they had done the right thing by signing the consent form, without discussing this with their partner. This was seen by the men as a huge responsibility for them to take on at the time, and weighed heavily on the men's' minds. Most of them felt they had 'no choice' but to sign the form as the consequences of not signing it may be that their partner dies. As they waited in the waiting room for their partners, the men started to justify their decision to sign the consent forms for hysterectomies:

'I haven't got much choice' (P1:12).

'...there's not much I can do' (P3:12).

'I just left it in their hands because there wasn't a thing I could do' (P7:44).

The men were, at the time of their partners' medical emergency, quite accepting of what the healthcare professionals decided to do in regards to managing their partner's complications after childbirth. For example, when the obstetrician was unable to stop

one man's partner from bleeding after giving birth, he called in another obstetrician to assist him. The man could hear the two obstetricians discussing taking his partner to the operating theatre to perform a hysterectomy, as they thought it would be the only way to stop the bleeding. The obstetrician then informed the man that he had 'decided a hysterectomy was the best thing.'

'They (doctors) were there quite a while trying to patch her up, getting more advice from other medicos and decided a hysterectomy was the best thing' (P9:13).

4.2.3.2 Men not knowing partners' outcomes

For many of the men, when the obstetrician spoke to them at the time of their partner's transfer into the operating theatre, it was often very brief. The obstetrician explained they were not sure of their partner's 'outcome.' The men would often farewell their partners at the operating theatre doors, only to be left with thoughts that they were going to be single fathers, bringing up their children single-handedly. For example, one man thought he was going to be a single father when the obstetrician told him:

'...(partner's name deleted) is a very, very sick girl'(sic) and then she (obstetrician) broke it down to the point where she said her brain is frying, her BP is going through the roof, she's losing blood at a great rate of knots, her kidneys are packing up...as (partner's name deleted) was being wheeled into theatre the doctor turns around to him and says "say goodbye to your wife because we don't know the outcome"...and they took her to theatre' (P4:13).

At those times the men experienced feelings of disbelief and helplessness. They were, however, accepting of what the healthcare professionals do to attend to all the physiological needs of their partner:

'Yeah it was all a bit sudden. My daughter was 11 weeks prem and (partner's name deleted) had placenta praevia...I'm on the phone talking to her (partner's) mother and this guy came out in a white coat, a surgeon, or a doctor came out with his hat on and said, "Can you come here for a minute I've got something I've got to tell you", and he said, "oh, we can't stop the bleeding"...if we can't stop it well we're going to have to do, "we're going to

have to do a hysterectomy". I suppose, it's what they ended up doing anyway' (P1:1).

Many men felt that any information regarding the condition of their partners would help them deal with the emotional stress they were feeling. For one man to try and keep his mind off his partner (who was in the operating theatre) the man would quickly visit their newborn infant, who was in a nursery on another floor. He would then run back to the waiting area hoping to hear from a healthcare professional for news of his partner:

'No, no there was no communication, I found that to be a little bit hard...you are not getting angry with somebody, all you are saying is help her ...I was just tooing and froing that night, so trying to keep my mind off things, just going up to see (newborn infant's name deleted)...I would go up and see her and then I'd think well I'd better go downstairs' (P11:13).

4.2.3.3 Communication and imparting of information

Men, however, who were given regular updates of their partners' conditions by the healthcare professionals while their partners were in the operating theatre, were less anxious than the men who had no forthcoming information. One man stated that the obstetrician came out to talk to him again after his partner, who had a PPH, was taken into the operating theatre. He said it gave him an opportunity to ask some questions he had, and that 'five minutes in total' was enough to allay his anxieties (P12:5).

4.2.3.4 Left alone to wait

When women experience complications after childbirth, such as haemorrhaging, the men are often taken or directed to a waiting room to wait. This was one of the most frustrating and annoying times for the men, when their partners were in the operating theatre as they didn't know how long they would be in there and had no idea of where to go or what to do in the meantime. Waiting with nothing to do or no information

was the most difficult part. Most wanted to visit their newborn infant but worried that if they left the theatre waiting room they may miss the doctor, and not get information regarding their partners.

One man was with his partner when their infant daughter was born by elective caesarean section. His partner began haemorrhaging soon after the delivery and he was asked to leave the operating theatre. A midwife took him to the theatre waiting room and left him alone. He wanted to visit his newborn infant but was worried that healthcare professionals might come out of theatre to give him information about his partner. He noticed the theatre reception was empty and was unable to leave a message to tell anyone looking for him he would be visiting his infant daughter. He describes how he ran between the floors visiting his newborn infant and then waiting in the theatre waiting room:

'I kept waiting, I kept waiting, I'm waiting for the word, I'm waiting for news so I wanted to be, it was so funny because I was almost running at times because I'd go up the stairs and I'd be with one and I'd think "oh, hang on they (healthcare professionals) might be wanting me," so I'd go back down again, then I'd go back up again, I remember it was really weird...I was trying to think rationally...there was an area there (theatre) which was a receptionist type area and there was no-one there, it wasn't manned and that was annoying, that would have been good, ...if there was someone there I would have said "look my wife's just had an operation, dah, dah, dah, I'm going upstairs (to visit newborn) if anyone needs me I'll be on the ninth floor"...but I couldn't do that because there was no-one...I couldn't even get a message in there... I remember thinking this probably just a fact of life...this day and age, there's no nurses, no nothing...they (hospital administration) just cut it to the bone' (P3:42).

The healthcare professionals were described as behaving as if the mens' partners had no family or no one who is connected or cares for them. They seem to be oblivious to the suffering that the men were going through and had no systematic approach to care or support them. Equally the hospitals seemed to have no system set up that ensured the partners and relatives were incorporated in the care they provided. Men were left

waiting for hours in waiting rooms, too scared to leave in case a healthcare professional came to talk to them to give them a progress report on their partner. During this stressful period they also experienced strong feelings of guilt about not visiting their newborn infant.

One man waited 5 hours in an ICU waiting room. Only when the morning shift commenced did an ICU nurse see him and asked who he was waiting for. His partner had been back from theatre and had been in ICU for 4 hours and no one had come to see him to inform him of his partner's ICU admission. He did not spend time with his newborn infant at this time as worried if he left the waiting room the healthcare professionals would not know where to find him. He still finds this upsetting:

'...there was a nurse that came in and by this time it was early, about seven in the morning...Yeah, five or six (hours) probably...just waiting in the waiting room...pulling my hair out really..., she said, "I will go in and see how your wife is going," so they (ICU nurses) didn't even know I was in there (ICU waiting room)' (P11:14).

4.2.3.5 Feeling lucky

The men who had someone, a layperson, nun or a family member take them for a sandwich or a cup of tea or coffee, while their partner was in the operating theatre, felt they were 'lucky'. The men were often not thirsty or hungry but were relieved to be occupied with thoughts other than that of their partner in the operating theatre. For example, one man felt 'lucky' when a nun came and gave him support by offering to take him for a cup of coffee during the time his partner was in theatre. Even though he didn't feel like it at the time it gave him something else to focus on:

'...a nun came up to me...she asked me if I was alright, if I wanted to sit down and have a cup of coffee and have a talk. She was really good. They were sort of working on the baby at the same time as doing the blood transfusion so I was sort of standing around, it was lucky she took me off somewhere because I

don't know what I would do...even though it wasn't what you wanted, it was somebody saying, "Look come with me and get a cup of tea"' (P1:8).

One man, who had family with him when his partner was taken to theatre after experiencing complications after childbirth, felt 'lucky' to have them there with him:

'I was probably lucky 'cos (partner's name deleted) parents were at the hospital so we went to the canteen...I think if I had been on my own that would not have been good' (P12:15).

4.2.3.6 Wanting reassurance and guidance

The men were accepting of bad communication from medical staff when they felt their partners were receiving the best care. One man stated to his partner that her obstetrician better be 'good' because his bedside manner was 'not much good':

'I said "God, he'd (obstetrician) want to be good" and she (partner's name deleted) said 'he is' because I said 'his bedside manner is not much good' and she goes 'no it's not, he's not a big communicator, if you've got a question he'll answer it, but he's quite grumpy too at times' (P3:47).

Sometimes the men just wanted reassurance from the healthcare professional that this was not an unusual occurrence and that some women do experience difficult complications after childbirth do occur. One man thought that even if the doctor 'lied' about the situation his partner was in, it would have been 'nice' to have received some reassurance:

'Well, even some reassurance. Just someone to say well look it is a difficult situation, but what they normally do is this, this and this. Just to let me know – okay well that is the normal procedure and someone will hopefully to say that – well it's not unusual to call in another doctor, even if it's a lie. It would have been nice' (P3:15).

4.2.3.7 Partner missing out

In a few cases, the men were asked by the nursing staff if they wanted to feed or bath their newborn infant while their partner was in ICU. Each man reacted differently due to the stress they were under, and each had different plans of what they were going to

do once their infant was born. They had discussed with their partners such things as breastfeeding, bottle-feeding, bathing the newborn infant, and so on. For example, one man did not see his newborn infant for the first 36 hours and was quite offended by a midwife asking him if he wanted to bath his newborn infant son with her. He explained that this was something special that (partner's name deleted) and he were looking forward to, bathing (newborn infant's name deleted) for the first time. He was angry that his partner's health crisis, post delivery, 'took this away' and 'she missed out on all that'. He was hurt that he, his partner and newborn infant son would 'never get that back.' He was quite rude to the nurse stating that:

'...people (nurses) are stupid, I really honestly believe that, I know, nurses were trying to do the right thing, but I didn't want to bath the baby, it's one of those things that hurt me, sincerely, 'cause I knew that (partner's name deleted) wanted to do that...I think that their (midwives) hearts were in the right spot...it's upsetting...we (he and his partner) were meant to be there doing this together, first baby you are meant to be bathing, breast, trying to breast feed and all those sorts of things and she (partner) missed out on all that' (P8:13).

4.3 The relationships and interactions with healthcare professionals

In some instances the men felt that the healthcare system had let him, his partner and newborn infant down.

4.3.1 In relation to care delivery to the partner and newborn infant

In some cases, the men thought that the healthcare professionals did not deem their partners as important as other birthing women. These men felt that the healthcare professionals could do more to assist their partners birthing process. One man's partner had given birth to an infant boy and 10 minutes later her partner noticed, 'she was turning white' (P8:25). The umbilical cord had snapped and the placenta was retained and she began to haemorrhage. The obstetrician informed him and his partner that she needed to go to the operating theatre to have the retained placenta removed. The man's partner had to wait 45 minutes until the theatre, which was currently

occupied by a woman who was undergoing a caesarean section, was free before doctors could move his partner into theatre to remove the placenta. During this time she remained on a theatre trolley and was receiving a blood transfusion:

‘...she needed a blood transfusion immediately because she was losing blood, the placenta had become detached and was still in her...they couldn’t get her into theatre immediately because there was another lady having a breech birth, so she had to wait on one of those trolleys while they finished off this other woman who they deemed was a lot more important than my wife...point is it is unacceptable that in a country like Australia somebody can turn around and say to you, “look we can’t do anything about it actually, we already have somebody in theatre”’ (P8:25).

4.3.1.1 Let down by the healthcare system

One man felt that the healthcare professionals in their local hospital did not conduct a thorough investigation and tests on his partner, even though she remained a patient in their emergency department overnight. This man’s partner was 35 weeks pregnant and was experiencing abdominal pains. She went to their local doctor, who said ‘it’s probably something you’ve eaten.’ She also attended her obstetrician who told them ‘she was ok’. Later that night she was screaming in pain, so he took his partner to the local hospital. The medical staff stated that it was probably gallstones, by this time the man stated:

‘...my blood was boiling, I said, “well, do some tests for it” and they said, “we’ll give you (partner) some Pethidine...” we knew from (older child’s name deleted) when you have peth, they’re (newborn infants) a bit sluggish... so we weren’t really fussed but first priority was to get (partner’s name deleted) right’ (P4:3).

His partner was discharged the next day with no clear diagnosis. Later that morning his partner began to experience abdominal pains again and started to bleed heavily. This time he took his partner to the maternity hospital she was booked in to have the infant. On arriving in the hospital a midwife on doing an internal examination called the obstetrician immediately. Within minutes half a dozen healthcare professionals

surrounded his partner. He was in a ‘combination of shock and anger’ as his partner was quickly diagnosed with HELLP syndrome (Haemolytic anaemia, elevated liver enzymes, and low platelet count)¹⁵ and is whisked away for an emergency caesarean section. He was shocked and angered that his partner had not been diagnosed with HELLP syndrome at the local hospital only hours before when she was in the emergency department:

‘...a bit of shock really...it was a combination of shock and anger. Anger that they should have picked it up at (name of hospital deleted) ... and then all of a sudden there’s like seven people in the room...phum (exclamation) full on’ (P4:10).

4.3.2 The relationship and interactions with healthcare professionals during the crisis prior to admission to ICU

During the men’s partners’ obstetric crisis the men were often left alone waiting for news of their partner. In many cases the women were taken to theatre and in this time the men were left to wait in the theatre or ICU waiting room. Often the men were left waiting alone and with little communication from the healthcare professionals.

4.3.2.1 Partner about to die

Often when the men’s partners were admitted to ICU they then had to wait before they were allowed to visit. Sometimes the men were kept waiting in the ICU waiting area for hours before they were allowed to visit their partners in ICU. During this time some men had thoughts that their partner had died and that was why they were kept waiting so long. Finally, when a healthcare professional came out to the ICU waiting area to tell one man he was allowed to visit his partner in ICU, he thought he was only being allowed into ICU to visit his partner because she was about to die:

¹⁵ HELLP syndrome is a life-threatening obstetric complication considered by many to be a variant of pre-eclampsia. Both conditions occur during the latter stages of pregnancy, or sometimes after childbirth.

'Yeah, you get a bit sceptical in a way because I remember thinking at one stage that the only reason they (healthcare professionals) let me in here (ICU) was she (his partner) was about to die...it's all a bit vague, it's all a bit fuzzy but I'm pretty sure the only way I got in there is because I just barged my way in there' (P3:33).

One man who was given no guidance of what to do when his partner was in ICU and his newborn infant was in the nursery felt like a 'shag on a rock:'

'I thought in some respects, I felt like a bit of a shag on a rock, you know, do I go and sit with (partner's name deleted), do I go sit with (newborn infant's name deleted)?' (P13:8).

4.3.2.2 Body language

When everything was going smoothly, the communication flowed freely between healthcare professionals and the men. When the crisis happened there was no longer that open communication. The men commented that they could tell by the body language of the doctors and nurses that there was problem. The men found that non-verbal cues, such as body language, led them have a negative thoughts as opposed to where the men were given more open verbal communication from the healthcare professionals.

After the birth of their newborn infant, one of the men just knew something was not right with his partner, but was accepting of what the doctor was doing:

'I realised things were not going to plan when the doctor was...mopping up and trying to clean up and stop the bleeding and called another doctor in to help' (P12:1).

Initially the healthcare professionals said nothing to him, but he could tell by the concern on the doctors face there was something wrong. He was accepting of this, as the obstetrician:

'...was too busy doing what he was doing.' The man during this time was holding onto his newborn son for "about 20 minutes, maybe, or an hour or

so” while the doctor tried to stop the bleeding. “He (doctor) was looking overly concerned, you could see the expression on his face, things not going well’ (P12:1).

Men questioned why the healthcare professionals didn’t speak freely to them and tell them they were experiencing problems with their partner’s delivery. Men would look at the body language of the healthcare professionals and be able to tell there were problems, but this was not conveyed openly to them. At this time they are just trying to digest all that is being told to them, or deciphering the body language of staff that indicates they are concerned. Looking for any cues as to partner’s condition is:

‘You could tell that they (nurses) were very worried...and they had (partner’s name deleted) interests at heart...’ (P3:34).

Another man stated that he could tell by looking at the midwife’s facial expression that something was wrong but instead of verbalizing this to him and his partner she whispered something to her colleague: *‘...midwife’s face changes and she goes, ‘sps, sps, sps,’ you know sort of whispering distressed’ (P4:11).*

At the time, leading up to the obstetric crisis, the men couldn’t understand, and were quite surprised, as to why it took the healthcare professionals a while to work out there were obstetric complications:

‘I was in there (theatre) and they (healthcare professionals) just did it all, delivered the baby...stitched her back up and then there were problems...there was a lot of bleeding...that got really scary... I’m still surprised they actually stitched her all the way back up before they realised anything, because I would have thought that you would realise before then’ (P3:12).

One man sensed the nursing staff knew more than they were divulging to him, as he could tell by their ‘body language’ (P2:4). He took this to mean that the nursing staff were protecting themselves, by not verbalizing their concerns to him, and were waiting for the doctor to speak to him. He felt that if the nursing staff had talked more

freely to him this would have lead to his fear about the condition of his partner being slightly alleviated: *'I feel for them, it must be a terrible position to be in. It was like they had their guard up' (P2:4).*

In some cases, the way the healthcare professional approached the men gave them an indication that the information he was about to hear was not going to be good. For example, one man knew by looking at the doctor, his body language and the way he sat down, that he was about to tell him something that would upset him. He knew his partner was critically ill:

'I could tell by his (doctor's) body language he was going to say something upsetting...and then he (doctor) sat down...like you would sit down and tell somebody someone is going to die' (P8:7).

In some instances the men could tell by looking at the ICU nurses' faces that they did not think things were 'very good' when looking after his partner. On watching the faces of the ICU nursing staff that were attending to his partner's birth he could sense that not all was well. Nurses explained that his partner's blood pressure was down because she had lost a lot of blood and they were transfusing her to improve her blood pressure:

'I remember saying that's not very good (the low blood pressure) and he just said "no it's not very good" but...they (ICU nurses) just said "Look, she's been through a very long operation and she is worn out"' (P4:12).

4.3.2.3 Accepting of physiological assaults on partner during time of crisis

The participants were accepting of the treatment at the time but later they were questioning the decisions made by the healthcare professionals. The men understood that at times of crisis the healthcare professionals excluded them from the decision-making process. However, healthcare professionals failed then to acknowledge and

support the men's need for information, particularly during crucial times of high anxiety and fear. The men were accepting of physiological assaults on their partner at the time of crisis, but it affected them differently at a later date, which was related to the lack of clarification or explanations at the time by the healthcare professionals: *'I stayed out of their (healthcare professionals) way and let them do what they had to do' (P13:30).*

During the time the men's partners were experiencing complications after childbirth, the men were accepting of what the healthcare professionals divulged to them. The men felt that it was their 'role' to 'keep out of their way' and not to question what the healthcare professionals were doing. One man said that the healthcare professionals, and his, 'main concern' was to stop his partner's bleeding:

'...there is not much I can do'...I was there but not there if you know what I mean. They were just busily working on (partner's name deleted) to do the best to stop the bleeding. That was their main concern. That was my main concern. My role was to keep out of their (healthcare professionals) way. It's as simple as that. There are no 'ifs or buts'. They (healthcare professionals) are there to do their job and I am there to support where I could' (P11:4).

4.3.2.4 Surreal situation

Sometimes the situation, his partner's complications after childbirth, seemed 'surreal.' The men couldn't believe what was happening. Here one man describes how 'surreal' the situation was as he sat in the waiting room holding his newborn infant and he heard a 'Code Blue'¹⁶ and knew it was for his partner. He was given his newborn boy in the waiting room by a nurse and was told that another nurse would be out to explain the condition of his partner. He was left in the waiting room holding his newborn infant and heard a 'Code Blue' called and he knew it to be for his partner:

¹⁶ Emergency code called in a hospital to alert staff to attend a patient who has had a cardiac arrest.

'Surreal, they, nurses, bring out a nice little boy and then say my wife is dying!'
(P7:2).

The men tended to neglect looking after themselves when their partner was admitted to ICU. Some of the men didn't eat and became 'quite gaunt', forgot to shave and were dishevelled. For them their partner in ICU was a 'surreal' experience. Another man also said that the whole experience of his partner admission to ICU after complications after childbirth was:

'it was just all-surreal...surreal...I was a mess I was...I was terrible...I had probably twice as much growth as I have now. I was quite gaunt 'cos I hadn't eaten, very, very worn out. I have never seen myself like that (P8:14).

For the men, visiting their partner in ICU for the first time, it was an extremely traumatic experience for them. Removed from the maternity hospital and now situated in a strange technological environment they seemed to be in a state of suspended animation. One man said it was not 'real' (his partner's admission to ICU after childbirth) and that it was like being in the movies: *'...not real. It was like being in the movies and I thought only in the movies' (P12:11).*

4.3.2.5 Digesting information

When their partners were admitted to ICU the men were often quite unprepared for the amount of scientific and medical information that the healthcare professionals would give them. Sometimes the men were told that their partner had more than one medical problem that the healthcare professionals were treating. This often led to men asking for the healthcare professionals to translate the medical terminology to layman terms. For example, one man whose partner was in ICU was told that his partner had 'an embolism¹⁷ in her lungs.' He needed to enquire what an 'embolism' was:

¹⁷ blood clot

'She (doctor) said "...we have a bit of a problem" she said she had an "embolism in her lungs" and I said what was that and she said it was "a clot"...she said her kidneys started to fail, her blood got fine, and her liver started to bleed... and she was on a respirator or some stuff like that...I can't remember the sequence at the moment' (P8:5).

Some men felt the doctors when explaining medical conditions of their partners were clinical and very insensitive. One man was enquiring why his partner's eyes were so swollen and looked like they had 'popped out'. He asked if it was the medication she was on and was told that it could be swelling of the brain with no further clarification: *'...no that's swelling of the brain...there could be bleeding' (P8:5).*

4.3.2.6 Visiting in ICU

The men found it difficult not only to try to understand what the healthcare professionals had told them but also found it quite distressing visiting their partners in ICU. For most of the men it was their first time visiting someone in ICU and the explanations from the healthcare professionals did not prepare them for appearance of their partner, who was surrounded by ICU equipment.

In some cases even though the healthcare professionals had given the men information, regarding the ICU environment and partner's condition and appearance, the ICU environment and the appearance of their partner still came as a shock when they went in to visit. For some men seeing their partners, who had experienced complications immediately after childbirth, in ICU for the first time was emotional. Seeing their partner's appearance led to some of the men to break down and cry:

'I went in there (ICU) and (partner's name deleted) just looked terrible and it made it worse...into ICU and I sort of just broke up and started crying and trying to be strong for her at the same time' (P11:15)

4.3.2.7 Impressions of ICU

For some of the men visiting their partner in ICU was overwhelming. The intensive care environment affected the length of the man's visit when visiting his partner in ICU. In most cases the men's visits were brief and only a few words were exchanged:

'I went in and had a look at her, had one or two words and that was it basically. By that stage I had had enough of intensive care to be honest' (P9:13).

For some men the layout of the ICU was upsetting for them, as it made them feel depressed and claustrophobic. One man thought that the ICU looked like something out of the 'Crimean War'. He likened the ICU, which had a long row of beds along a wall, to pictures he had seen of hospital wards taken during the time of the Crimean War:

'Crimean War and all that. That is the thing that immediately came to mind. I wanted to get her out of there because it was a depressing sight and claustrophobic as well, they were all shoulder-to-shoulder there' (P9:13).

4.3.2.8 Feeling sorry for others

While waiting in the ICU waiting rooms some of the men had empathy for the other ICU patient's families and struck up a conversation, which also helped them get their mind off thoughts of their partner who was in theatre. One man, who had been rung up at home during the night, and was left, waiting in the ICU waiting room while his partner was in theatre, struck up 'some idle chit-chat' with another ICU patient's relatives. He felt sorry for them, as they had to travel a long way to visit their relative in ICU. He felt lucky that he didn't have far to come, and if he wanted to, could stay with family that lived closer to the hospital:

'...I really felt sorry for them 'cos they were actually staying in the hospital at that time, as they had no where else to stay...geez, what makes it worse for them is that they are not even in their own city...completely out of their surroundings and I mean not that I live near the hospital or anything like that

but to me I drove not to far, whereas, they had to make a big trip to get to where they are now, and I suppose you have always got the option of going home or whatever. It was a lot harder for them, so I think you just try to get interested to try to get your mind off what is going on' (P11:11).

4.3.2.9 Sit down and take stock

Men felt that before their partners were discharged from either the maternity hospital or the ICU they would have benefited from a discussion with one or more of the healthcare professionals. Some of the men expressed that talking about his experience, or given the opportunity to ask questions, with a healthcare professional may have assisted them to gain some understanding of the events in a meaningful way and therefore reach a sense of resolution, that by discussing with a healthcare professional his feelings of isolation, powerless, helplessness and anger at an early stage may have assisted them work through feelings of resentment.

One man said that 24-48 hours after his partner had been admitted to ICU and her condition had stabilised and his newborn infant was well, it was then that he 'took stock' and the reality of the situation caught up with him. He said that he looked like he was 'travelling' a lot better than he displayed and needed to talk to someone about the previous 24-48 hours events. This man also stated that he needed 'guidance':

'I think probably the second day about 24-48 hours later...would have been good if someone had taken me and said, "look let's go to the quiet room...get out of here...let's just sit down and take stock of what has happened to you"...perhaps I look like I'm travelling ok...to give me guidance to how you may feel. "Look this is how you may feel"' (P12:39).

In some cases the men were told their partners were 'doing really well' but this did not prepare them for their partner's appearance when they first visited:

'...overall, bloodshot to the max, like unbelievable. She (partner) almost looked like the devil, the whites of her eyes were all flat out red...and whatever else and then the physician will say she's doing really well' (P4:29).

Some of the women's appearance shocked the men because of their bloated appearance. One man thought that his partner looked like she had put on '10-15 kilograms' and thought she looked 'gi'normous':

'I reckon she probably would have put on probably 10-15 kilograms. Oh, she was gi'normous' (P4:32).

Another man describes his partner as looking ill and looking 'really bloated up':

'just looked ill and she looked really bad, she was really bloated up and she lost a lot of blood, a heap of blood she lost (P11:12).

Seeing his partner in ICU was 'one of the most distressing times' in his life:

'That just left an impression on me you know. I hadn't seen anything like it before...basically lying there with all the other monitoring and measuring instruments, but to see all the other sick patients in ICU' (P9:4).

Another man could not believe what was happening to his partner who had a seizure after childbirth. His partner had:

'...all the various scans MRI, CT and blood tests...I mean they told us nothing. I think they (healthcare professionals) knew nothing. All they said was there is a nurse there by her bed 24 hours monitoring her. All the tests came back 'AI', so everyone was still baffled thereafter' (P16:6).

4.3.2.10 At the mercy of healthcare professionals

A common description as to how the men felt when their partner was in ICU, after experiencing complications after childbirth, was that of 'helplessness'. The men realised that there is nothing medically that they could do, and that their partners' wellbeing was in the hands of the healthcare professionals. Here one man describes how he and his partner were 'helpless' and at the 'mercy' of the healthcare professionals during his partner's admission to ICU:

'Yeah, well it is just so hard to come to terms with the fact that you are so helpless...you are just at the mercy of everyone around her (partner), and hopefully they are looking after her...she looked really bad, she was really bloated up, and she lost a lot of blood, a heap of blood...she was breathing

through a mask and she had like a thousand different things around her' (P9:15).

4.3.3 The relationship and interactions with healthcare professionals during the crisis during the admission to ICU

In the intensive care environment you would expect that the healthcare professionals who worked there to be aware of the stress that the family members are under when loved ones are admitted to ICU but this was not always the case.

4.3.3.1 Flustered and upset

The men whose partners are admitted to ICU immediately after childbirth complications were also stressed and dealing with their emotions. So it is disappointing when healthcare professionals speak insensitively to family members. The healthcare professionals need to be aware that at the time of the admission of a loved one to ICU the family is *'flustered and upset'* and can interpret the way of what is said to them incorrectly:

'...people (healthcare professionals) have to deal with emotions and when you're a little bit "flustered and upset" you sort of tend to interpret things in a completely different ways...so the last thing I needed was someone to just brush me off and, um, be little, you know, non-chalant' (P8:6).

4.3.3.2 Detached, very clinical and apathetic

Sometimes the healthcare professionals spoke clinically and insensitively to the men when explaining their partner's condition to them. For most of the men this was the first time they had been into an ICU. One man's partner was admitted to ICU and asked the doctor why were her eyes so swollen, 'she had very, very swollen eyes...eyes had popped out' (P8:5). He thought it might have been the effects of *'medication'* but was told by the ICU doctor, rather clinically and apathetically that, 'she has swelling of the brain...she could be bleeding,' he thought it, '...so

insensitive, it was completely clinical...completely but completely detached, very clinical and apathetic' (P8:6). Whereas, he felt she could have explained it better, 'you say, "well we have got swelling of the brain...we are monitoring it... and hopefully nothing will..." you know' (P8:6).

4.3.3.3 Healthcare professionals in a hurry

The men understand that the healthcare professionals have as their common goal the welfare of their partners and were accepting that their needs for answers were not always met. They look at the contributing factor to this lack of communication is the high pace of the intensive care environment.

The men wanted to ask the healthcare professionals questions regarding the progress and prognosis of their critically ill partner but were put off as they saw them as being in a hurry. The men viewed this as healthcare professionals not having time to spend with them to give them any answers to their questions:

'The people (healthcare professionals) I needed to talk to get those answers were always in such a hurry because they had to get back in there (theatre)...so they wouldn't have any time and for that very same reason I didn't want to hold their time up either' (P3:46).

4.3.3.4 Importance of a family meeting

It is important for healthcare professionals to speak to the family members in layperson's terms and to clarify what they have said is what the family members have heard. Often when visiting a 'loved one' in ICU information can be misinterpreted due to the stress that the family are under. Having a family meeting with the ICU healthcare professionals is a good way to communicate to the whole family the patient's condition and planned treatment.

One man confirmed that having family meetings in ICU was beneficial so that a healthcare professional, such as a doctor, nurse or social worker, could sit with the family and explain exactly what is going on in ‘layman’s terms’. The men found the medical terminology was difficult to make sense of. The healthcare professional that is running the family meeting needed to be compassionate and able to break down the jargon so that all the family could understand what was being said:

‘...in that situation you need somebody who is compassionate and can...put it in layman’s terms so you can understand...when they (healthcare professionals) give you those big words, they need to break it down...so that all the family can understand...and hear from one person’ (P8:6).

4.4 Impact on the men and their families during their partners’ admission to ICU

The men expressed that even though healthcare professionals had given them explanations regarding their partners’ condition, while they were in ICU, the men still felt fear and intrepidation and embarked on a process of ‘trying to cope.’

4.4.1. Too afraid to ask questions

One man seeing his partner for the first time in ICU, noticing how ‘awful’ and ‘all white’ she looked, glanced at a cardiac monitor and thought his partner’s blood pressure was low; nonetheless, he didn’t want to ask the healthcare professionals any questions, as he was afraid of what the answer might be. He was ‘petrified’ as all he could do was watch the monitors and try to decipher what the healthcare professional was saying:

‘...she’s just lying there and she looked awful and she was all white and then you see some of the instruments, this is probably why they don’t want you in here, and you hear them (healthcare professionals) talking about the blood, I mean I couldn’t believe the blood pressure, her blood pressure was like 55/20 all I ever hear of is 160/80...and you think that’s nowhere near 160/80, that can’t be good. I was thinking at what read out do you die... I didn’t ask it

because I didn't want to know because if they had of said 54/19 I would have...gone bonkers...I was petrified' (P3:32).

4.4.2 Juggling visits between two hospitals

In seven cases, the seriousness of the men's partners' deteriorating condition warranted the transfer of the women to an ICU in another hospital. This resulted in the newborn infants remaining in the hospital where the women gave birth. In two instances newborn infants required transferring to another hospital's Neonatal Intensive Care Unit (NICU). Men struggled with the decision of where they should be, with their partner or with their newborn. Some of the men who had their partner in one hospital and newborn infant in another hospital were trying to 'work out' how much time to spend with their partner and newborn infant: *'just trying to work out, do you spend the time with your wife or do you go back to the baby?'* (P16:10).

4.4.3 Trying to deal with it

In some instances the men said that they would have liked to have been told by the healthcare professionals to contact family, or just the simple things such as offering to take the man for a cup of coffee or briefly explain to them what was happening to their partner, or even a time frame as to how long it would be before his partner would be transferred from theatre to ICU:

'...you're always having to put up defences I think, not to let people in so, you're just trying to deal with it yourself so, I probably would have liked somebody just to grab my hand and say look this is what's happening, you'll be able to see your wife at this time, you can go and see your baby then, in the meantime I suggest you get some family or something or other or come down and talk to us, just something like that, you know' (P1:6)

4.4.3.1 Coping mechanisms

Not having any idea how long their partners would be in theatre was daunting for the men. To try and justify the length of time their partners had been in theatre men used

various strategies to cope. One man described how he used information he gained from watching television programs, to try to help him gauge how long it would be before his partner, who was in theatre due to complications of bleeding after childbirth, should be out of theatre:

'You watch ER or that sort of stuff ...operation, three hours... you hear about it on the news or you watch 'A Current Affair', they say about a heart transplant that took three or five hours, seven hours or whatever, yeah, because that's the thing that I just couldn't handle, I mean all I had I had to go by is the movies and stuff...you're talking about hours, you're talking about really serious stuff' (P3:26).

4.4.3.2 Unexpected complications after childbirth

In some cases the man's partner is in one hospital and his newborn infant is in a completely different hospital. The men said they found it 'pretty hard' when their partners' condition improved to the point where they wanted to see their newborn infant, but due to the logistics, or the degree of illness of woman and the newborn infant it was not always possible to unite both mother and newborn infant. One man's partner on waking in ICU, from a chemically induced coma, asked to see their newborn infant but both his partner and newborn infant were too sick to leave their respective ICUs for a few more days. He stated that:

'It was a couple of days before she (his partner) could see her (newborn infant). So that was pretty hard' (P1:9).

4.4.4 Impact on family members (including children)

To try to keep themselves busy some men rang up family members while their partner was in theatre. They would speak to their other children who were staying with supportive relatives or friends:

'I'd sit there for a while and think, "Oh, this is driving me mad," and I'd have to move around. At one stage I rang up, that's right, I actually rang up my daughter then and um, just to see, just to say... and I was actually in a pretty

bad way...I mean wasn't really thinking, I was just, I just had to speak to someone' (P4:40).

4.4.4.1 In relation to newborn infant

As the men's partners' condition improved while they were in ICU they would discuss with their partner whether to bring the newborn infant to ICU to visit.

4.4.4.2 Not to bring newborn infant into ICU

Some of the couples decided against bringing the newborn infant to ICU, as they were worried that the infant might contract an infection from another ICU patient. By keeping their newborn infant away from the intensive care environment the couple believed that their newborn infant would be 'safe as possible.' One couple that decided not to bring their newborn infant to ICU to visit the man's partner, made the decision based on concern for the safety of their newborn:

'...we decided not to bring the babe into ICU because intensive care...there are a lot of people...infections... serious illnesses, so we decided to keep the baby away and as safe as possible' (P16:12).

4.4.4.3 In relation to other children

The men, whose partners were admitted into ICU after experiencing complications after childbirth, also needed to make decisions regarding older children visiting their mother in ICU.

4.4.4.4 Decisions regarding other children visiting ICU

Some of the men had older children and decided not to take them to ICU to visit their mother. For example, one man did not want to take his children into the intensive care environment, and only took them in to visit their mother when she was transferred into a ward. He said he based this decision on the fact that while in ICU she was

‘quite sore’, couldn’t move properly and needed to get her senses together, so made the decision to visit her alone:

‘I remember her (his partner) being quite sore...it was just a matter of getting her out of intensive care, and I didn’t want to take the kids because obviously you can’t take too many visitors there. I was the only one that went in for the first few days, and then she was taken to the ward’ (P9:9).

He also stated that seeing the other people in ICU left an impression and thought this might affect his other children, if he took them in to visit their mother in ICU. What concerned him was the condition of the other patients. He knew that his partner’s state of health was improving and that she would not be in ICU for very long as opposed to some of the other intensive care patients:

‘I have seen my mum in intensive care with heart problems and that sort of thing, so I have seen all the monitors and that was no big deal but just the people. There was a young chap who was completely yellow, I had never seen anything like it.’ (P15:13).

4.4.5. Impact on men’s well-being

Most of the men made a conscious decision to wait until their partners were safely out of theatre and admitted to ICU before ringing their family and in-laws. The men were conscious of the in-laws being elderly and not being able to do anything, and so elected not to contact them at the time of crisis. One man’s parents and in-laws came in to visit him while his partner was in operating theatre. He tried to explain to them what had preceded his partner’s admission to theatre, after suffering complications after childbirth, without breaking down. His in-laws were confused as they had all been in earlier to visit his partner, their daughter, and newborn infant:

‘Yeah, they ended up coming in...trying to hold back my emotions and was really choked up in the throat and talking to them...you know from sheer joy to just...the whole world around you is going to collapse in on you, so you know, it wasn’t a good time’ (P11:9).

The addition of a newborn infant into the family brings about more intense changes than many other developmental stages of the family unit. The stress these men experienced led to marital and family difficulties because the crisis not only affects the man but also has an impact on the family as a whole. One man argues a lot with his partner and has become ‘bitter’:

‘I am bitter I was bitter with my wife and I am bitter still I think she knows this it is not a secret’ (P8:23).

4.4.5.1 In relation to other family members

The men had to co-ordinate visits from his and his partners’ parents, sisters, brothers as well as his own children.

4.4.5.2 Coordinating extended family visits to ICU

One man’s in-laws came to visit their daughter, who had just been admitted to ICU after experiencing complications after childbirth. His in-laws had brought the man’s older children in to visit their mother. The man was not convinced that his partner was as ‘stable’ enough to have visitors, so he urged his in-laws and his children to visit the newborn infant, stating they could catch up with his partner when she was ‘stable’. He promised he would ring his in-laws and his older children later with an update on his partner’s progress. He said:

‘...we’ll go see the baby and we’ll catch up when everybody’s stable. I said that she’s (partner) out of surgery which is one step forward...but I wasn’t convinced. You know they wanted to come, because all the kids wanted to come in and see the baby’ (P3:39).

4.4.5.3 Limiting time spent with partner in ICU

Some of the men were conscious of the time spent with their partner in ICU. One man limited the time he spent with his partner in ICU after nursing staff said that she

needed as much rest as possible. He knew that while he stayed with his partner in ICU she would try to stay awake and ask questions about their newborn infant:

'A lot of the time when she was in intensive care they (healthcare professionals) did emphasise she needed to have a rest and I knew she hadn't had a rest so the decision was easier for me. I thought if I am down there (in ICU) she is going to want to talk or whatever, so at least if I leave her alone she can actually have a bit of a sleep' (P9:10).

4.4.5.2 Through the dangerous period

Some men, on visiting their partner in ICU, saw it as a positive step. The men stated that they viewed the time of their partners' obstetric crisis the 'dangerous period' where they were 'the most worried.' The men described the admission of their partner to ICU as a positive step 'on the up and up.' These men said that the worst was behind them and once their partner was in ICU:

'Yeah, so that all went well. From then on in it was all fine basically because it was all on the up and up...once we got through that dangerous period...was where I was the most worried. After that it was always, it never got worse' (P3:46).

Even though some of the men's partners were in ICU for a few days the men viewed their partner's condition as 'moving on,' and 'improving.' Here a man expresses how he viewed his partner's admission to ICU:

'(partner's name deleted) was there for a few days and moved out and just kept moving on from there' (P11:53).

4.5 Men's fears and anxieties during the crises and their legacy

Some men were not given information as to where their newborn infants were when their partner was in theatre. This was often the case if the man was asked to leave the theatre when their partner experienced complications after a caesarean section. Often because of the urgency the men were asked to wait in the theatre or ICU waiting room. In most cases they were given no information as to which nursery their

newborn infant could be found. The men were beside themselves ‘wandering’ the hospital floors trying to locate their newborn infants. Sometimes the men would locate a nurse that they knew and would ask them if they could help find their newborn infant:

‘And at times it went through my mind to say where’s (infant’s name deleted)? You know, where’s my son? And then so I wandered up and um umm I didn’t know where he was. I went upstairs, because I knew quite a few of the nurses up there so I just asked them’ (P3:37).

4.5.1 Feeling petrified

Those men who were asked abruptly to leave the theatre by a healthcare professional when their partners were experiencing complications were ‘petrified.’ Although the men did leave, in most cases they did so ‘reluctantly’, and would often wait alone in the waiting room. While they waited many of the men were not offered any explanation of what was happening or support. During this time the men were petrified and experienced feelings of concern, uncertainty, panic, confusion and impending death of their partner. One man described being ‘whisked out’ of theatre and left in the waiting area, which he described as ‘horrendous:’

‘I know the doctor said something I just can’t remember his exact words...I was pretty petrified myself...they had to tell me twice because I didn’t want to leave...and then I did leave, reluctantly but that was tough because you could tell that there was a little bit of panic because you could just tell it wasn’t going according to plan and this wasn’t meant to happen. They (nurses) wanted to do tests on the baby they took (partner’s name deleted) away and then I was sort of whisked out...that was hard, it was pretty hard, too. You’re out of the room (theatre) and I’m just sitting there...Once I was out in the waiting room it was horrendous, because it was a long time. I mean, I don’t know how long – it seemed like days. It was probably about an hour and a half, I didn’t stay there all the time because I was just too toey, and I was just there by myself. There was no one there, there were no people around, so I don’t think I lasted very long. I said bugger this and then I started trying to get back in (to theatre)’ (P3:14).

4.5.2 Helpless to assist partner

The next situation highlights the sense of helplessness experienced by men even in the presence of healthcare professionals. One man, while holding his partner during her obstetric crisis, and watching her drift in and out of consciousness realises that he was ‘helpless’ to assist her:

‘I was helpless...it was really quite concerning when I’m holding her and she is sort of wafting in and out of consciousness...quite pale and cold’ (P12:6).

4.5.3. Feeling invisible

Several of the participants described being made to feel ‘invisible’ and ‘ignored’ during the time of their partners’ crises. These men just wanted to be given some direction or some guidance from the healthcare professionals, to be told where to go to wait. Each of the men needed to know that the healthcare professionals would know where to find him once they had stabilised their partner. For example, one man who witnessed his partner’s collapse and called for help then watched on helplessly as the healthcare professionals began resuscitating his partner. He found it distressing to hear the healthcare professionals say they had ‘lost her pulse and blood pressure’. He was standing in the corner of the room holding their newborn infant and watching, not know what to do or where to go. He felt so invisible and ignored that he actually stood in the healthcare professionals’ way so as to alert them that he and his infant were still in the room. He stated:

‘Yeah, and it’s probably fair to say that at least for the next ten or fifteen minutes...(infants name deleted) and I were just invisible. No-one had anything to do with us. So at some point I just barged in amongst them all, just grabbed her hand and just started talking to her...I think perhaps as a result of me just diving in and getting in the way, one of the nurses...I do then recall one of the nurses saying, “Look, I think you should get (infant’s name deleted) back to special care, we’ll look after things here”’ (P5:7).

4.5.4 Thoughts that their partner might die

In one case, a man whose partner had given birth earlier that day, was rung up at 3 a.m. by a midwife was told 'your wife's bleeding'. There was no more information given, except that he was needed in the hospital 'now'. The midwife said he would be given more information when he arrived at the hospital, as she was not in the position to give him any more information. He tried to explain that he had to organise someone to look after his daughter, so it may be some time before he could get there. After ringing a neighbour to look after his 3-year-old daughter he drove in to the hospital with feelings of foreboding that his partner 'might die' and he would be bringing up two children on his own. The midwife told him:

'... "come in now"...I thought this was it...a lot of things were going through my mind as I was driving to the hospital, "How am I going to bring up two children on my own? She might die. 'Cause a person who is profusely bleeding, you can die from that"' (P2:4).

4.5.4.1. Touch and go

One man's partner was in an adult ICU and his newborn infant, who was born at 29 weeks gestation, in a NICU. He had to juggle visits to two different ICU's as well as caring for their other children. He said that at the time his partner was in ICU he, and the healthcare professionals, thought that she might die. The healthcare professionals told him that it 'was like touch and go' and that on waking from her drug induced coma she may have 'brain damage.' He expressed that the experience for him at that time was 'pretty traumatic:'

'She (partner) was like touch and go, they (healthcare professionals) didn't know whether she had brain damage and all that sort of stuff, oh, I forgot about that (emotional) I must say it was a pretty traumatic time' (P1:4).

When another man's partner was admitted to ICU an obstetrician was explaining to him the seriousness of his partner's condition, after experiencing complications after

childbirth. He thought he was having a really, really bad nightmare, and began to physically ‘hitting’ himself, hoping this would wake him up, and find that the doctor and the information he was disclosing to him was just a nightmare:

‘...is this real? I thought this is one of those really, really bad nightmares...I was even hitting myself...I was saying to (doctor’s name)...are you here for real?’ (P8:8).

4.5.5 Men physically unwell

After giving the healthcare professionals consent to perform lifesaving procedures on their partners, due to complications after childbirth, the men watched their partners being taken into the theatre. For many of the men watching their partners being taken to the operating theatre brought on feelings of being physically unwell. The men, watching their partners being wheeled into the operating theatre, experienced feelings of nausea, stomach cramps and palpitations. After their partner had been taken into the operating theatre the men were then left to wait alone, not knowing what to do:

‘...my gut was just turning and my heart was just racing and I felt sick, I felt ill, fatigued and stressed... so they (health professionals) just took her in (to theatre). I thought what do I do now, there was nobody there and they hadn’t told me anything and there was this little waiting room’ (P11:8).

Similarly some of the men, when entering the ICU to visit their partner or newborn infant, experienced physical signs of nausea, dizziness, palpitations and fatigue. One participant was visiting his newborn infant for the first time in NICU he staggered and nearly fainted. His thoughts were: *‘that was a bit weak of you (man’s name deleted)’ (P1:2).*

Another man visiting his partner in ICU was nauseated, as the doctor was explaining that his partner could die from the complications experienced after childbirth: ‘I just wanted to vomit, and the doctor asked me if I needed a bowl, no, I just pulled myself together’ (P11:8). He felt that the whole experience when visiting his partner in ICU

was stressful and it made him feel ill and he experienced palpitations: “...my gut was turning and my heart was racing and I felt sick, fatigued and stressed’ (P11:8).

4.5.6 Feeling alone and isolated

While waiting for word on their partners in theatre, the feeling of aloneness and isolation was reiterated by many of the men. These feelings were exacerbated by the absence of personal contact and the helplessness of not knowing what to do or where to go and not knowing what was happening to their partners. They wanted someone to talk to, some one to fill in the void they were in. To remedy the feelings of loneliness and isolation one man sought out a public telephone so that he could talk to family:

‘It’s the time, trying to fill in the time while the unknown is being done, you know things that you don’t know ...sort of like a trance at times but it just seemed so empty, there was never anyone there and in a way, ...I wanted to talk to someone ...I wanted people to talk to me or someone just to say here’s a coffee and you know other people have been through this...because the thing that strikes me more than anything over that whole day was loneliness, was isolation, I remember when I went out to the visiting room and when I rang up from there...the pay phone there and again there was no-one there, I just remember everywhere I went there was not-one there and it would have just been good to talk’ (P1:9).

4.5.7 Feeling torn

Separated from partner and newborn infant, the men often did not know where their partner, or newborn infant, were within the hospital or hospitals, whom to ask or how to obtain the information to start with. The men felt that they were neglecting their newborn infant and this lead to feelings of guilt:

‘...it’s almost being drawn between the two, I remember thinking well (newborn infant’s name deleted) being neglected sort of, thinking maybe I should go up there you know, and I was feeling a bit guilty because...poor thing she’s got no-one with her’ (P11:1).

The men who were given no direction said they felt ‘torn.’ They felt at a loss as to who to visit and how long to stay with them. The men did not know if they should be

with their partner or with their newborn infant. They had feelings of guilt if they were with one and not the other and vice-versa. One man explained how he felt ‘torn’ not knowing where to be or who to be with:

‘So then I am sort of standing there thinking well what do I do now. So I had to wait, because then I was sort of torn, I didn’t know, because I had the baby on one floor and (partner’s name deleted) on another floor. So I couldn’t see (partner’s name deleted) because they had to do this thing and she was out of it ...I hadn’t actually seen my daughter at this stage’ (P1:2).

The word ‘torn’ was used by many of the men when describing how it felt for them to have to make the decision who to be with when their partner’s and newborn infant’s were in different hospitals:

‘...and you get torn because you...want to see (newborn infant’s name deleted) and you think I better go down and see (partner’s name deleted) and I’m all over the place...the worst experience I have had in my life to tell you the truth’ (P11:13).

4.5.8 Legacy of fears and anxieties

For many of the men the experience of watching their partner endure complications after childbirth, and her subsequent admission to ICU, has left them with memories of that time that cannot be erased.

4.5.8.1 Scary memories

One man had the tragic experience of his partner being in ICU and daughter dying in a NICU in another hospital. He and his partner had attended counselling but he decided not to continue as the sessions made him relive the painful memories and he didn’t want to be reminded of that time again. The memories he said took him to: *‘a very scary place. I don’t want to remind myself of that situation again’ (P6:10).*

However, some of the men said it was good to talk to other people about the experience of their partner being admitted to ICU immediately after childbirth and to hear that others had had a similar experience. As one man said:

‘There was a nurse who relayed that either she or her sister had had a very similar experience. It was funny over the next couple of months the more people we talked to about the experience, somebody would know somebody that went through something similar’ (P16:12).

4.5.8.2 Never forget

None of the men in this study were diagnosed with Post Traumatic Stress Disorder (PTSD), however, it is acknowledged some were severely traumatised by their partners’ obstetric crisis. Some of the men who witnessed the pain and suffering of their partner found it a frightening experience and have become traumatised. These men have been emotionally affected by the events of a traumatic birth. Some of the men still experience ‘flashbacks’ and ‘nightmare’ months and even years since their partner experienced complications after childbirth, which required them to be admitted to ICU. In some instances these symptoms can be likened to the spectrum (continuum) of Anxiety Disorders as set out in DSM-IV (1994). As the object of this study was to describe men’s experiences of the incidence and impact of their partners being admitted into an ICU following childbirth and no attempt was made to diagnose or classify these symptoms, no one particular diagnosis can be made. However, the researcher was strongly reminded during analysis of the semi-structured interviews of some of the symptoms of PTSD. Although these men were referred to counselling, it was their decision to accept or reject this offer. In the absence of anything but an intuitive sense of a diagnosis, the researcher had no pathway of care for referral.

Since their partners' discharge from ICU many of the men expressed that they will never be able to get those images out of their minds. Some have had counselling but have not found it helpful as it takes them back to feelings they wish to suppress.

'...but I will never forget, I mean, I'll never, I don't think I'll ever, it will always be in my mind. I don't think anything would fix that, make it come out of there' (P7:25).

Another man says that the experience of watching the healthcare professionals "working" on his partner after she experienced complications after childbirth is something that still "haunts" him and something he will "never forget" (P4:16):

'I'll never forget it and it still sort of haunts me a bit, I've never seen, it's like working on a hunk of meat...it's unbelievable, there was three doctors working and her whole body is just shaking with the work, so flat out' (P4:16).

4.5.8.3 Ignore it

Another man said that he did not want counselling, as he did not want to be reminded of the time his partner suffered complications after childbirth which required her admission to ICU: *'I guess, I guess I just ignore it because I don't want to be reminded of that situation again' (P6:15).*

One man thought the healthcare professionals were very insensitive toward him, as they told him not to let his partner do much around the house when she was discharged. He resented this as he knew how weak and anaemic his partner was after complications she had experienced after childbirth. He said the healthcare professionals spoke to him in a 'chastising way' which he 'resented:'

'I remember somebody making a comment about it, as if it wasn't really obvious to me, you know how anaemic my wife was and how I had to make sure she didn't do anything. I was almost told in a chastising way, and I really resented that, because I thought "you've got no idea", and this is the day I went to pick her up, I've been sitting through all this, don't tell me what I have to do, I know what my responsibilities are and I wouldn't dream of

allowing her to do that. So I had to almost guarantee that before they'd let me take her, and I thought that was a bit silly' (P2:19-20).

4.5.8.4 Depression exacerbated

Some of the men found it very difficult to concentrate at work since they experienced their partners' traumatic birth and admission to ICU immediately after childbirth. One of the men said that he now has a 'tendency to get upset' and sometimes he cannot explain why. He stated, that he suffered from depression prior to his partner's admission to ICU but the experience has exacerbated his depression:

'with work, just work, you know, because I suffer from depression as well... well I have for a long time but, um, the truth is this has exacerbated my condition without a doubt it has severely, um, it has severely increased the tendency to get upset, you get upset for nothing' (13:35).

4.6 The impact on men and their future life plans

The impact of men whose partners were admitted to ICU immediately after childbirth has affected each man's future life plans differently.

4.6.1 Decision not to have more children

For some men and their partners they have decided not to have any more children due to their partners' complications suffered after childbirth and subsequent ICU admission to ICU. In these cases their partners have not always agreed initially and many-heated discussions occurred. One man watched his partner experience complications after the arrival of their second child and decided not to have more children. He believed, at the time they made the decision not to have another child, she could quite possibly die during childbirth based on the complications she had experienced after the birth of their second child. They both regret not having a third child:

'I have to say that last experience prevented us from having a third child. We both now regret not having a third, but I said to my wife "it's not worth it, I don't want to bring up 3 children on my own." It was so life threatening and I don't know whether it could happen again, the doctor couldn't predict it either. If the uterus had ruptured, it could have been fatal' (P2:14).

The experience of witnessing their partners' complications after childbirth has led some of the men to say 'No more children' as they are extremely worried that their partners will experience complications after a subsequent birth:

'No more children...no, no, I'm worried about my wife. Worried about more complications' (P10:7).

4.6.1.1 Consequences of another baby

The discussion to not have more children was not uniform. Some men and their partners have decided to have another child despite the woman's previous complications experienced after a previous birth. One couple waited almost two years before deciding to have another baby. This man said for the first year after his partner's admission into ICU after complications experienced after childbirth he thought:

'...what could be the consequences if she has another baby? Initially both of us said, "Do we take the risk?" So it does make you wary and question, "Are we ready for this now?"' (P14:7).

This man's partner was four months pregnant during the time of the interview and was asking the researcher medical questions, as he was concerned for his partner's health as she was exhibiting the same symptoms as she had during the first pregnancy. I needed to explain that I was not a doctor and he should, along with his partner, talk to their obstetrician.

In some cases the man and his partner argue about having or not having another baby. This man's partner asked the obstetrician about her becoming pregnant again when she visited him for her first obstetric check-up only 6 weeks after giving birth and

experiencing complications that required her to be admitted to ICU. The obstetrician stressed the point that if she had another baby she would probably require a hysterectomy immediately after the birth. Her partner is completely against her becoming pregnant again and has told her numerous times that he wants a vasectomy:

‘The obstetrician stressed the point “if you should have another one (baby) I will have to do a hysterectomy, your uterus just won’t handle another one,” yet she is determined to have 3 kids. I’m quite determined in my life not to have 3 kids, I want to go for the snip and she said, “no”’ (P12:56).

4.6.1.2 Obstetrician positive

Some men felt assured that complications after the birth would not occur after a subsequent birth, as the obstetricians assured them that they knew of her past history and was therefore alerted to what would need to be done to avoid complications.

For example, one couple was positive about having another baby after talking to the obstetrician at the 6-week postpartum check-up. The obstetrician was positive that the man’s partner would not experience complications after the delivery of another baby, as he would give her a drug that would ensure that the uterus would contract after childbirth:

‘The obstetrician positive...said it would be ok...they (healthcare professionals) would put a drug in to cause her uterus to contract after she has the baby’ (P11:62).

4.6.2 Impact on work

A few of the men’s partners had long-term hospitalisations prior to the birth and then experienced complications after childbirth, which warranted extended hospitalisation.

4.6.2.1 Couldn’t work

Men needed to juggle not only visiting a sick partner in hospital, a newborn infant, who was sometimes in another hospital, organise care for older children, as well as

reorganise work commitments. For one man, who was self-employed, his partner and newborn infant were in hospital and he needed to forgo work to care for his other children, which included a child with cerebral palsy. He would organise his day taking the children to school and then spend most of his time between visiting his partner in ICU and his newborn infant in NICU in another hospital. On his partner's discharge from hospital he would then take his partner, and sometimes their older children, to visit their newborn infant that was critically ill in NICU. At this time he did not work for 6 weeks and there was no income:

'...out of my control...everything...I couldn't work, I couldn't do anything...the bills still come in' (P6:23).

In most cases men, prior to their partner experiencing complications after childbirth, had applied for paternity leave. Often the leave was only a few days to a week to spend time at home with their partner, newborn infant and other children. Now after the admission of their partner to ICU men realised that they needed to apply for more leave so that they could assist their partner at home with their newborn infant, other children and general household duties. In some cases, their partners were not allowed to drive the car or pick up anything heavy, such as full washing basket. The men, who were stressed and realising they needed more time off from work were sometimes confrontational with their employer when asking for more time off.

When one man's partner was in ICU he needed more time off from work. He needed to visit his partner and newborn infant and take care of an older child. He was willing to resign if his employer refused his request for leave. He said he didn't negotiate with his employer, but confronted him and said he was ready to resign if he didn't get time off:

'I must have been quite stressed because I actually didn't negotiate. "If you want to sack me I don't care, this is what I need"' (P12:47).

4.6.2.2 Men's role in the household

The crisis of complications of birthing and its consequences has changed some of the men's roles in their household. One man is now not only a husband and father but the full time carer of his partner and baby. As a consequence of the lifesaving equipment used to save his partner's life she is now unable to care for their infant:

'...once she recovers 100% because it's only now that she's starting to lift the pram, you know, on her own, so I can't leave her alone...she's getting better but it will take at least a year, I think, at least a year' (P7:38).

The admission of their partner to ICU still affects the family as a whole. Some of the men's partners still require regular medical checkups due to the complications suffered after childbirth, as their road to recovery is still ongoing. One man's partner, who is on extended sick leave, still needs to attend a kidney and eye specialist as a result of complications post delivery:

'...but what is it now, it's been about 8 months and the truth is that only now has it begun to affect me, you know it affects me at my work' (P8:15).

4.6.2.3 Inability to work

Some men said the experience of their partner being admitted to ICU after complications experienced after childbirth has affected their ability to work, even though their workplace has been very supportive of them:

'Yeah, I had two weeks off work for the baby but ended up taking five weeks off 'cos my work was actually very supportive...but what is it now, it's been about 8 months and the truth is that only now has it begun to affect me, you know it affects me at my work (P8:15).

4.6.3 Annoyed with friends

For some of the men they become very annoyed when friends describe their partners' birthing experience as 'difficult.' One man is still very annoyed and upset about how sick his partner was after childbirth. He still remembers when she was in ICU and the doctor had told him that she might die. His partner has been on a long road to recovery and still requires visits to medical specialists. He has some male friends who have seen their partners go through a difficult childbirth, but not to the point where the doctor has said they might die. He is annoyed that when he talks about his partner's difficult childbirth, which required an admission to ICU, that his friends also say their partners also experienced a difficult childbirth. He is annoyed and upset that his friends don't understand just how sick she was:

'...this has exacerbated my condition (depression) without a doubt...the tendency to get upset...somebody might come in with a baby...and someone (a friend whose partner has just had a baby) will say... "the labour was so long, it just went on forever," and I'm like "big frigging deal"...and they say, "I suffered so much"...and you know, I get like in my head I get quite annoyed like 'cos I don't want to hear this shit, 'cos you have got no idea' (P8:15).

4.6.4 Family arguments

Some men are still upset when their partners say that they 'knew' when they were experiencing complications after childbirth and in ICU, that they 'knew' they would be alright and knew they were not going to die. The men argue that their partners were sedated and didn't realise how sick they were or how close to death they were. The men state that they were the ones watching their partners go through the crisis, worry if they were going to be left to bring up children by themselves, left to wait in the theatre or ICU waiting rooms for hours alone and the one to make decisions about their partner on her behalf:

'Oh yeah...I argue with my wife quite a few times and I remind her of how selfish she is...just to presume she is the only one who went through the

pain...you (partner's name deleted) didn't go through anything, you were on the bed (in ICU) and you were saying, "I never thought I would die, I knew I would be fine," I said, "yeah" (exclamation). I was the one running around, I was the one taking in all the information' (P8:16).

Some of the men each day consisted of juggling other children's childcare and schooling, home duties, keeping other family members up to date, managing work commitments, visiting his partner and newborn infant in hospital. For one man his partner's admission into ICU has caused some conflict in their marriage, as it allowed him to bond with his newborn infant in a way he couldn't with his older child. He would visit his partner in ICU then visit his newborn infant in the nursery and help bath and feed her. He asked the midwives to video him bathing and feeding his newborn infant so he could show his partner, as he knew she was missing out on this. He thought he was doing something positive and that it was the next best thing he could have done:

'...got heaps of video footage because I thought well (partner's name deleted) isn't going to see any of this...and I thought at least that way (partner's name deleted) not going to feel as though she missed out, it's on video, well, it's the next best thing that I thought that could have been done' (P4:28).

His partner sees the video featuring him and their newborn infant as evidence that he spent all of his time with their newborn infant and not visiting her in ICU. He told her he took the video so she could see what their newborn infant looked like and he knew she was missing out on bathing and feeding their newborn infant and wanted the next best thing for her. His partner still says he should have spent more time with her while she was in ICU and not their infant, and it is causing marital problems. He says that his partner says:

'... "You should've been spending more time with me", you know sort of thing and "Why were you spending so much time with (newborn infant's name deleted) when I was sick, why weren't you with me?"... so...' (P4:40).

4.6.5 Questioning healthcare professionals

Some men have become more questioning when meeting with healthcare professionals and state that it is a result of their partners' admission to ICU after complications experienced after childbirth. For example one man says that on different occasions he needed to take his children to hospital and when the healthcare professionals started to tell him 'what was going on' he became 'very questioning' demanding more information:

'As a result of that (partner's admission to ICU) I've become a very questioning person, like with my children, when both of them had to be in hospital for different things, the staff, or the registrar started to tell us what was going on and I just don't stand for that anymore, and they can't cope with that' (P2:21).

4.7.1 CONCLUSION

The data presented reveal the men's experiences within the healthcare system when their partners' birthing experience became an emergency and life-threatening event. The interviews revealed that deviation from normal birthing, the perceived life-threatening event of the birthing woman, and healthcare professionals care delivery processes themselves left the partner feeling outside the circle of the healthcare delivery system. Many of the men interviewed indicated that they felt as though they were left to be 'bystanders' to the events that unfolded and that, while in this position, they were left 'alone to struggle' and to cope with many unexpected and new difficulties that arose which they found horrifying and profoundly painful.

CHAPTER 5

DISCUSSION OF FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

In this chapter, attention is given to discussing the research findings presented in Chapter four of this study. In addition, conclusions are drawn and recommendations are made in regard to healthcare processes, policy and practice areas, which need to be, put in place in order to foster a good postpartum outcome for the men as well as their partner. Recommendations regarding future research in the area are also made. In preceding this discussion, firstly the aims and objectives of this research are outlined.

5.2 Aims and objectives of the study

The key aims of this research were to:

- Explore men's experiences and perceptions of the incidence and impact of their partners being admitted into an ICU following the complications of childbirth;
- Explore and describe the nature of the relationships and interactions that men have with healthcare professionals before, during and after their partner's ICU admission following the complications of childbirth;
- Discover what impact the experience of their partners being admitted into an ICU following the complications of childbirth had on the men's relationships with their partners, newborn child, and other children (if any);

- Discover what impact (if any) the experiences of their partners being admitted to ICU following the complications of childbirth had on their future life plans.

Objectives of this study were to:

- Discover what processes are used to support and involve men in the care of their partners and newborn child before, during and after their partner's ICU admission following the complications of childbirth;
- Identify any gaps that might exist in the care and support provided to the men whose partners were admitted to ICU following the complications of childbirth;
- Explore men's views on what processes they believe would best support them in the event of their partners being admitted to ICU following the complications of childbirth.

5.3 Discussion of findings

Overall, the findings of this study have discovered current healthcare policy and practice for men with their partners in life-threatening situations intrapartum and immediately postpartum failed sixteen families. The men were left isolated, alone and struggling. Every healthcare facility either has well-established patient and family support services 'in house' or can access such services both as inpatients and then within the community health services such as the Maternal Child and Health Centres and Community Mental Health Services. Healthcare policy and practice areas need to be improved in order to foster and promote better postpartum outcomes for men as well as their partners.

5.3.1 Antenatal classes

Most of the men interviewed for this study attended antenatal classes with their partner. These men expressed concern that the midwives who took the Antenatal classes had not disclosed that in some instances during childbirth women can experience complications. One man stated that he would have liked to have been informed that even if there was a '1%' chance that his partner could experience complications after childbirth he would have liked to have been informed. He thought that if the midwife had mentioned this he would have been more prepared for his partner's experience of having complications after childbirth.

Men who are aware of what to expect regarding complications that may occur during childbirth will be better able to support their partners during the time of an obstetric crisis. Nurses and childbirth educators are in key roles to educate men (and significant others) regarding labour, delivery and complications that may arise (Montgomery 2001).

5.3.2 Healthcare professional's interactions with the men

In some of the cases, the admission of a man's partner to ICU, immediately after childbirth, meant that his partner was transferred out of the maternity hospital, where she had given birth and admitted to an ICU in another hospital. This resulted in his partner and his newborn infant being separated, and he needed to juggle visit between hospitals. Often the men felt guilty and unsure of where they should be, visiting their partner who was critically ill in ICU or with their newborn infant. These men stated that they felt let down by the healthcare professionals as they did not offer guidance as to what to do in this case. It is important that the healthcare professionals give guidance and some direction to the men who find themselves in this difficult position.

The men should be given all honest and open communication regarding the condition of their critically ill partner, and on the basis of that information the men can then make a fully informed choice to visit their newborn. Healthcare professionals should give the men, in this case, a break down of their partners' condition prior to them visiting and then follow up with the men when they are at their partners' bedside. This would give the time men to take in the appearance of their partner and the physical environment of the ICU. By this time the men would probably be a bit more at ease to ask the healthcare professionals questions. Interventions aimed at meeting the men and his family's needs for information must not only be effective but practical.

In some cases men felt angry that their partner, who was in ICU, was missing out on doing what other 'Mum's' do after uncomplicated childbirth. Some of these men felt angry and disappointed that their partner was not involved in their newborn infant's first bath, first feed, and first change of the nappy. The admission of the men's partners' to ICU also took away their partners' opportunity to breast feed, which many of the women had planned to do. Healthcare professionals can in some cases, assist the post-natal women in ICU express their breasts to assist breast milk production. Often expressing of the breasts is something that is only considered when the critically ill post-natal woman is awake and asking for assistance from her partner and healthcare professionals to do so. Also, not all intensive care nurses are midwives and so they are unfamiliar with expressing milk using breast pumps and so often the post-natal women is unable to breastfeed her newborn infant. Breast expressing policy should be implemented within hospitals to assist those intensive care nurses, who do not have midwifery qualifications, instigate and assist the post-natal critically ill woman to express.

After witnessing their partners' birthing crisis and subsequent admission to ICU the men are at risk of being traumatised, as are their partners (DiMateo et al 1993). The men were emotionally affected and frightened by witnessing their partners' traumatic birthing experience. The men are at risk of secondary traumatic stress after witnessing their partners' complication after childbirth due to their intensely close relationship they have with one another (Figley 1986; Figley and Kleber 1995). The distress and trauma experienced by men during their birthing crisis may have prevented them meeting adequate emotional support to their partners in the short and the long term. Some of the men avoided and were unwilling to discuss, with their partners and family, their partners birthing crisis and admission to ICU immediately after childbirth. In addition, the men's unwillingness to discuss with their partner the experience of witnessing their partners' obstetric crisis may also be as a consequence of the perceived trauma, and may suggest an avoidance coping skill. Some of the men, who went to counselling, stopped attending because it brought back all the images of his partner in the crisis situation.

It is noted that none of the men were diagnosed with PTSD. However, there is scope to suggest that at the very least while unable to conclude that the men in this study had PTSD, as per DSM-IV (1994) diagnosis, they were certainly traumatised. The men witnessing their partners' obstetric complications were overwhelmed, and this hindered their normal ability to cope with stress, which has the potential risk of intensifying to PTSD. Some of the men, in this study, still experience flashbacks, nightmares, anger and irritability. These men also do not want to be reminded of their partners' obstetric crisis and try to avoid all reminders of this traumatic event.

Negative emotional states such as guilt and anger have been identified as common in PTSD and also associated with depression and anxiety (Joseph et al 1997).

The potential for trauma responses may be further increased when the man feels that his partner was left without adequate healthcare professional support during the time of his partner's obstetric crisis. Some of the men felt that the needs of other birthing mothers made it difficult for the healthcare professionals to deliver adequate attention and assistance to their partner during their obstetric crisis. It is important that healthcare professionals communicate with the men and their partners during the time of the obstetric crisis and follow up with further meetings while their partners are in the ICU, so that the men have time to ask questions regarding his critically ill partners' condition.

5.3.4 Financial burden

One point raised by some of the men in this study was the financial burden faced when their critically ill partner was in ICU. The financial burden faced by one man was brought up in the interview. He was self-employed and needed to look after his three school aged children, one whom had cerebral palsy. For six weeks he was unable to work and had no income during this time. He needed to stay at home to look after their child who had cerebral palsy, take and bring home the other children to and from school, feed the children and in between visit his partner in ICU. He relied heavily on his friends and neighbours during this stressful time. He said the bills still come in even though you're not earning an income: *'I couldn't work...the bills still come in'* (P6:23). It is important that healthcare professionals are alert and able to take on some responsibility to guide these men toward seeking some financial advice

and assistance to help reduce some of the stress these men are facing while their partner is in ICU.

5.3.5 Worried about the future

Some of the men were concerned about their partners' long-term health and were reluctant to have more children. These men feared that there was the possibility that if their partner became pregnant again she would again experience complications after childbirth, which would require another ICU admission. Often the first time the couple spoke about having another child was when the women went for her six-week post-natal check up with obstetrician. Some of the women would ask the obstetrician if it was alright to have another child and what were the chances of experiencing complications after childbirth. The men were taken aback as they had witnessed their partners' obstetric crisis and subsequent admission to ICU and were not prepared to take the risk of having another child. In some of the cases the obstetricians could not guarantee the woman and their partner that they would not experience complications after childbirth. These obstetricians did explain that if the woman did experience complications, after the birth of another child, that a hysterectomy might need to be performed.

The men were incredulous as to why their partners were so eager to have another child when she was so ill after the birth of their last child. One possibility is that the women, while experiencing complications after childbirth and then admitted to an ICU, were heavily sedated and therefore did not remember their time in ICU. Prior to discharge from the hospital the men and their partners should be able to discuss these issues with a healthcare professional.

5.4 Recommendations

5.4.1 Antenatal classes

Midwives taking Antenatal classes need to discuss and alert prospective parents to some of the complications that could be experienced during and after childbirth. Some childbirth education groups, such as Maternal and Child Health Nurses could extend the scope of their education and activities to encompass the postpartum period and facilitate the support network groups for new parents.

5.4.2 Empathetic healthcare professionals

The key to ensuring an effective healthcare professional and family relationship requires understanding the experience the partners of the critically ill. If the healthcare professionals assist, support and communicate openly with the men, whose partners have suffered complications after childbirth and have been admitted to ICU, they may minimise the overall impact of the trauma experienced by the men. This is achievable if the healthcare professionals show honesty, caring, consistent and empathic attitudes and involve the men in caring for their critically ill partner. The healthcare professionals should not only care for and manage the critically ill woman's physiological and technological needs, but also work toward establishing a productive relationship with her partner.

To minimise time spent in the waiting rooms at the hospital healthcare professionals may be able to provide daily or shift-by-shift telephone updates to the men so that they could optimise time spent at home with other children. Healthcare professionals could also suggest to the men that another family member could stay with his partner so that he is not overly fatigued. Healthcare professionals could assist the men by suggesting to the men that they ask family members to assist in certain responsibilities

that they have confronting them. The healthcare professionals could also provide information for the men to find adequate accommodation near the hospital using hospital and community resources can assist the men in obtaining appropriate rest and the chance to have a shower. Providing the men with information where they can obtain meals that are nutritious and well priced can aid the men in reducing financial stressors.

5.4.3 Maternal Child and Health Centres

The men and their families could be guided to attend support groups. Maternal Child Health Centres do have forums where couples can discuss their feelings regarding problems they faced during and after childbirth. This could provide a forum for the parents to talk about their traumatic birthing experience with other parents, which could be therapeutic for both the man and the woman. Providing a forum where both the man and the woman can discuss their birthing experience in the presence of other parents would be therapeutic and assist in the prevention of long-term consequences of the obstetric crisis that he and his partner experienced.

5.4.4 Policy making to guide healthcare professionals

Improve practice by developing a policy, within the maternity hospital, that enables the healthcare professionals to care and provide information to the man at the time of his partner's obstetric crisis. This policy should outline the processes to undertake when a woman experiences complications after childbirth, which requires her admission to ICU.

Healthcare professionals in ICU can give guidance to the partner of the critically ill woman who has been admitted to ICU immediately after childbirth. The healthcare

professionals should encourage the man to visit his newborn infant, who may be in another hospital to that of his critically ill partner. The intensive care healthcare professionals should encourage the man to take pictures of their newborn infant and bring them into his partner to see and place them where she can view them readily. The man should also be supported by the intensive care healthcare professionals to talk about the newborn infant to his critically partner. In some instances, it may be appropriate to bring the newborn infant into the intensive care environment for the mother to cuddle. The intensive care healthcare professionals can liaise with the nursery healthcare professionals if this is appropriate, and convey this to the man and his partner.

5.4.5 Notifying children's teachers

Johnson et al (1995) identified that when a family member is admitted to an ICU, the children's home responsibilities increase. The men should alert the school teachers, counsellors and school nurses that their partner is critically ill in hospital so they are alerted to the fact and are aware that the child/ren are at risk of stress and not able to concentrate at school.

5.4.6 Less restrictive visitation in the ICU

Healthcare professionals' perceptions of patient preferences are not always accurate and their attitudes are not always positive regarding family visitation in the ICU (Cullen et al 2003; Freismuth 1986). Positive philosophy and attitudes of healthcare professionals are paramount in promoting family visitation of the critically ill patient. Increasing family visitation has shown to increase family member's satisfaction within the context of the intensive care experience (Cullen et al 2003; Freismuth

1986). It is important for both the critically ill woman and her family that visitation in the intensive care environment is encouraged as this will help reduce patient and family's feelings of stress and anxiety.

5.4.7 Communication with men and family

Adequate preparation for the men is important prior to visiting their partner in the ICU. The healthcare professional should take some time to discuss their partner's condition and changed appearance, as well as the elements of the intensive care environment to help prepare him. Once the men are at their partners' bedside, the healthcare professional is now able to further update them regarding their partners' critical illness and prognosis. To allay the men's anxiety the healthcare professional can also discuss the interventions and equipment used to support and monitor their partner while she is in the ICU. Daily interaction with the wide range of the men's and their critically ill partners' emotions may be challenging and it may be necessary, for the healthcare professionals, to use the hospital support services which are available. Such examples are a social worker, priest, nun or counsellor.

5.5.8 Counselling

Some of the men, if still traumatised by the experience of witnessing their partners' obstetric crisis, may benefit from private counselling. Childbirth events that involve life-threatening injury are likely to give rise to trauma reactions (Wijma et al 1997). Prior to the men's partners' discharge from the hospital the healthcare professionals should give the contact name and phone number for him to contact. In some hospitals the social workers are available to give counselling to the men and give them some information regarding support services within the man's and his partner's community. Healthcare professionals should advocate for men and their families to

ensure that they receive appropriate follow-up care and counselling when discharged home.

5.5.9 Benefits of Debriefing

Debriefing is a primary prevention strategy to allay, or at least prevent acute stress reactions that usually take place 24 to 72 hours after the event (Busuttil & Busuttil, 1997). Debriefing is a one-time, semi-structured conversation with an individual who has just experienced a stressful or traumatic event. In most cases, the purpose of debriefing is to reduce any possibility of psychological harm by informing people about their experience or allowing them to talk about it.

In debriefing with a healthcare professional it would allow the men to discuss and clarify feelings and worries they might have, and give them the opportunity to ask any pertinent questions they might have. Prior to the men's partners discharge from hospital it would be beneficial for the man, along with his partner, to be involved in a debriefing session with an ICU or maternity hospital healthcare professional. Debriefing would give the man time to ask questions and discuss his feelings and anxieties that he might have. It would also give his partner the opportunity to hear about his experience, so that she could have some insight what it was like for him during that crisis period.

Debriefing is a form of interpersonal interaction that would assist the men to illuminate the presenting concern, verbalise their feelings, and if need be, to identify goals and decide on a plan of action (Busuttil & Busuttil, (1997). As the man gains a realistic perception of the crisis event his partner experienced he should develop sufficient coping skills so that the escalation of trauma symptoms may be abated.

Interviewing these men has demonstrated that they are often left with many questions and concerns for a long time, even years, after experiencing their partners' obstetric crisis and subsequent admission to an ICU.

5.5.10 Future research

Arising from the findings of this research it is evident that gaps exist in the current research regarding the impact on men where their partners are admitted to an ICU immediately after childbirth. Further research is required so that healthcare professionals looking after critically ill women can better determine and implement interventions to assist these critically ill women's partner. There needs to be further research into the men's experiences and perceptions with a focus on how healthcare professionals can be better able to put in place appropriate support strategies.

5.6 CONCLUSION

In conclusion, within this chapter consideration has been given to discussing the research findings forwarded in Chapter Four of this study. This chapter has highlighted several key areas of concern for healthcare professionals practice and recommendations have been made to enhance the provision of care for men whose partners have been admitted to an ICU immediately after childbirth.

Study targets men after crisis births

By Larissa Ham

CRITICAL care nurse Janine Parsons is exploring a topic rarely touched on.

Mrs Parsons, who is completing a Masters of Nursing at RMIT, is researching how men cope if their wives have to go into intensive care after giving birth.

The Blackburn resident said she had "tapped into a difficult area" because men often shied away from the topic, and their wives might not understand the pressure they were under.

"The men are worried about the baby, worried about the woman, they've got other children, they've got to notify their wife's family," Mrs Parsons said.

"They don't tell you in antenatal clinic the percentage of women that need to go into intensive care.

"It's something they (men) don't think about.

"I just don't think men talk about it."

The mother being separated from her baby, and crisis situations such as hysterectomies, also

caused confusion, she said.

Mrs Parsons is looking for 20 men willing to discuss their experiences in a one-hour taped interview.

She has 15 years' experience in intensive care, and works at St Vincent's Hospital.

Her masters study is aimed at improving care for men going through difficult times surrounding childbirth.

To take part, phone Mrs Parsons on 9877 1221, or email jasest@bigpond.com.au.

media release

NEWS • EVENTS • RESEARCH • EXPERT COMMENTS • NEWS • EVENTS • RESEARCH • EXPERT COMMENTS

Volunteers Needed for Childbirth Study

RMIT University Masters of Nursing student, Janine Parsons is researching men's experience of their partners' childbirth. Janine is looking at how men cope with this important time, particularly when the childbirth is complicated.

Janine Parsons is seeking volunteers for a study on the experiences of men whose partners have been admitted into an Intensive Care Unit (ICU) immediately after childbirth.

Janine is an intensive care nurse in a large metropolitan teaching hospital with 15 years experience in intensive care.

It is hoped this research will identify what healthcare professionals can do to improve the care of men who are placed in such a distressing situation.

Men whose partners were admitted into an ICU immediately after childbirth, and who are interested in participating, are asked to contact:

Janine Parsons, Tel: (telephone number deleted) or e-mail: (email address deleted)

Media contact:

(RMIT Publicist name deleted), Publicist, RMIT University – (work phone number deleted) or (mobile phone number deleted).

APPENDIX 3

(Name of Hospital deleted)

Date

The supportive needs of men whose partners have been admitted into a Critical Care Unit immediately after childbirth

As you were recently in the Intensive Care Unit at (Name of hospital deleted) we would like to invite your partner to participate in a study. We have a research student who would like to interview the partners of women who were admitted into an Intensive Care Unit immediately after childbirth.

The study is aimed at identifying and describing supportive measures that critical care nurses offer to partners of women who have been admitted into an Intensive Care Unit immediately after childbirth. Understanding his experience may assist the intensive care nurses to better meet men's supportive needs during this stressful situation.

The researcher's interest comes from being a critical care nurse who has cared for women who have been admitted into an Intensive Care Unit immediately after childbirth.

The information would be collected by taping the interviews, using a tape-recorder. The interview would last no longer than 1.5 hours. The meeting place and time would be mutually agreed to. Participation in the study is voluntary and all information would remain confidential. Anonymity will be assured. Your partner may withdraw from the study at anytime, without prejudice.

If your partner is not interested in being contacted please phone (Name of Intensive Care Secretary deleted) on (Contact phone number deleted) and no further contact will be made. If, after 2 weeks from the date of this letter, your partner is interested in participating only then will your phone number be given to the researcher.

If you or your partner would like to contact the researcher for further information please call Janine Parsons on (Contact phone number deleted) during business hours, or mobile 0408 388 064.

Thankyou

(Name of Intensive Care Unit Data Manager deleted)
Intensive Care Unit Data Manager
(Name of hospital deleted)

APPENDIX 4

Division of Nursing and Midwifery

INFORMATION LETTER FOR MATERNAL CHILD & HEALTH NURSES

My name is Janine Parsons. I am an Intensive Care Nurse working in an Intensive Care Unit (ICU) in a large Melbourne teaching hospital. The following is a brief overview of my research.

Title: "The experiences of men whose partners have been admitted into an Intensive Care Unit (ICU) immediately after childbirth."

While working in intensive care I have observed and cared for critically ill women who have just given birth and require the technical support of our unit. In some of these circumstances there is also an infant death. Understandably, their partners appear overwhelmed by this unexpected experience.

I would like these men to share their experience with me as it has the possibility of identifying and meeting the supportive needs of men who find themselves in these circumstances. Understanding their experience can enable the Intensive Care Nurse to better meet their supportive needs during this stressful situation.

The information will be collected during an interview, lasting no more than 1.5 hours. The interviews will be tape-recorded, transcribed and analysed.

All information will remain confidential. Anonymity will be assured. The participants may withdraw from the study at anytime without prejudice.

I realise this is a brief overview of my research. So, if you have any queries please do not hesitate to contact me. I am more than happy to speak to you again, if you wish.

Thank you for your time.

Janine Parsons
Master of Nursing Student-RMIT University
(H) (Home phone number deleted)
(M) (Mobile phone number deleted)

APPENDIX 5

Division of Nursing and Midwifery Plain language statement for research participants

The Experience of Men whose Partners have been Admitted into an Intensive Care Unit (ICU) Immediately after Childbirth.

Background

I am interested in interviewing men whose partners have been admitted into an ICU immediately after childbirth. My interest comes from being an intensive care nurse, and a research student, who has cared for women who have been admitted into an ICU immediately after childbirth. Understandably, their partners appear overwhelmed by this unexpected experience.

Purpose

I would like you to share your experience with me, as it has the possibility of identifying and describing the supportive needs of men who find themselves in these circumstances.

Procedure

What I would like to do is meet with you for an interview. I would like to tape the interview, using a tape recorder. You will be asked to discuss your experience of when your partner was a patient in the ICU. The type of questions will be "Tell me about your experience leading up to your partner's admission into ICU?" The interview would last no more than 1.5 hours. You can choose the time and place of your interview.

I will ensure that the tape and transcription will be coded so that anonymity and confidentiality is maintained. All information you give to me will remain confidential. All data related to the study will be kept in a locked filing cabinet for a period of 5 years. Participation in this study is entirely voluntary and you may withdraw from the study at any time without prejudice.

Please complete and sign the consent form prior to commencement of the study.

If you have any queries please contact me on (researcher's work phone number deleted) during business hours or email: (researcher's email address deleted).

Yours sincerely,

Janine Parsons
Research Student
Division of Nursing and Midwifery
RMIT University, Bundoora

APPENDIX 6

Division of Nursing and Midwifery

Consent form for participants

Full Project Title: The experiences of men whose partners have been admitted into an Intensive Care Unit immediately after childbirth.

I have read, or have had read to me in my first language, and I understand the Participant Information version 1 dated 17th June, 2003.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

Participant's Name (printed)

Signature

Date

Name of Witness to Participant's Signature (printed)

.....

Signature

Date

Researcher's Name (printed)

Signature

Date

Note: All parties signing the Consent Form must date their own signature.

Participant Information & Consent Form, Version 1, Date:

APPENDIX 7

Division of Nursing and Midwifery

The Experience of Men whose Partners have been Admitted to an ICU immediately after childbirth

INTERVIEW QUESTIONS

- Tell me about your experience leading up to your partner's admission to ICU?
- Tell me about your experiences and perceptions of the incidence and impact of your partner being admitted to ICU following the complications of childbirth?
- Tell me about the nature of the relationships and interactions that you had with healthcare professionals before/during/after your partner's ICU admission following the complications of childbirth?
- Tell me about the impact of the experience of having your partner admitted to ICU following the complications of childbirth?
- Tell me what you did when your partner was in theatre/ICU?
- What information did you receive from nursing staff/medical staff/others while your partner was in theatre/ICU?
- Tell me how you visited your newborn infant while your partner was in theatre/ICU?
- Tell me how your newborn infant was brought to visit your partner in ICU?
- Tell me how you looked after your other child/children while your partner was in ICU?

- How did you manage to get time off work?
- How did not working impact on your family?
- Tell me how you told your parents/in-laws/children about your partner's obstetric crisis and subsequent admission to ICU?

APPENDIX 8

6th March 2002

Janine Marie Parsons
62 Street
BLACKBURN 3130

Dear Ms Parsons,

FLSAPP 39-01 PARSONS The supportive needs of men whose partners have been admitted into a Critical Care Unit immediately after childbirth.

Thank you for submitting your amended application for review.

I am pleased to inform you that the committee has approved your application for a period of two years effective from the date of this letter. Your research may now proceed.

The committee would like to remind you that annual reports are due during December for all research projects that have been approved by the Faculty Human Research Ethics Committee.

The necessary form can be found at:
www.rmit.edu/departments/secretariat/hrec/html

Yours faithfully,



Chair, Faculty Human Research Ethics Sub-Committee
Faculty of Life Sciences

cc: Professor

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